1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10977

Reg. Dist. No.

1098T

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 1601 Columbia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Kyle — Last: Alderson

4. DATE OF DEATH: Month: October — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 15, 1951

9. AGE (In years last birthday): 5 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Kyle Henry Alderson, Jr.

14. MOTHER'S MAIDEN NAME: Joyce Marlene Unzicker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Kyle Alderson; same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Marasmus — INTERVAL BETWEEN ONSET AND DEATH:

351x

DUE TO (b): Cerebral palsy, congenital.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.

EXAMINER'S NAME (Type): John T. Maloney, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: October 25, 1957

22a. BURIAL, CREMATION, ~~REMOVAL~~ (Specify): Burial

22b. DATE THEREOF: Oct. 29, 1957

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS CO.

ADDRESS: 517 11th St., S.E., Wash., D.C.

24a. REC'D BY REGISTRAR DATE: OCT 28 '57

24b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
3M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10988 — Reg. Dist. No. 10978

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
c. LENGTH OF STAY IN 1b: 18 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4017 Webster Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Brentwood
d. STREET ADDRESS: 4017 Webster
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Raymond — Last: Allen

4. DATE OF DEATH: Month: October — Day: 21 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-8-01

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace W. Allen

14. MOTHER'S MAIDEN NAME: Ellen Fields

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mary M. Allen; 1602 N. Bryant St., Arlington, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

442 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John D. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 21, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 10-24-57

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

22d. LOCATION (City, town, or county) (State): Prince Geo. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Henry S. Washington & Son 467 N St. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: OCT 23 '57

24b. REGISTRAR'S SIGNATURE: Wm Leavick

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG222 11-6-57 et

10989

CERTIFICATE OF DEATH

10979
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Upper Marlboro
d. STREET ADDRESS: Rt 2 Box 178
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Juanita; Middle:; Last: Allen

4. DATE OF DEATH: Month: Oct. Day: 31 Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-20-19

9. AGE (In years last birthday): 37 89 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Chapman

14. MOTHER'S MAIDEN NAME: Maude Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Leroy Chapman Address: Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive intra Ventricular Hem left — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive A.S. Heart Disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-31, 1957, to 10-31, 1957, that I last saw the deceased alive on 10-31, 1957, and that death occurred at 10:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ronald Fleischer M.D. ADDRESS (Street, city or town, state): 5432 Queens Chapel Rd DATE SIGNED: 11/1/57

PHYSICIAN'S NAME (Type): RONALD S. FLEISCHER Hyattsville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11.5.57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery

22d. LOCATION (City, town, or county) (State): Upper Marlboro, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert G. McGuire 1820 9th St., N.W. Washington, D.C

24a. REC'D BY REGISTRAR DATE: NOV 4 '57

24b. REGISTRAR'S SIGNATURE:

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10990 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10980

Item 3 Film 6224 1/23/58 GTE

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 33 Bladensburg
d. STREET ADDRESS: 3563 55th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle also known Harrison — Last Marcellus Anthony

4. DATE OF DEATH: Month October — Day 25 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-11-29

9. AGE (In years last birthday): 28 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman

10b. KIND OF BUSINESS OR INDUSTRY: wrapping machines

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Anthony

14. MOTHER'S MAIDEN NAME: Cora Stout

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes -marines-1953

16. SOCIAL SECURITY NO.: 226-36-7597

17. INFORMANT — Address: Julian Williams, 6227 Akron Street, Wash., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock [redacted]
DUE TO
(b): [redacted] Gunshot wound of abdomen
DUE TO
(c):

981X

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Shot by another person.

20c. TIME OF INJURY — Hour [redacted] p. m. — Month, Day, Year: 10-25- 1957

20d. INJURY OCCURRED — While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) Bladensburg (County) Pr. Geo. (State) Md.

21. I certify thot I took chorge of the remoins described obave, held an Autopsy ☒ Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Naturol causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined monner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.

EXAMINER'S NAME (Type): John T. Maloney, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: October 25, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/28/57

22c. NAME OF CEMETERY OR CREMATORY: Henderson Cemetery

22d. LOCATION (City, town, or county) (State): Hyattsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: F Gischs sons

ADDRESS: Hyattsville Md

24a. REC'D BY REGISTRAR — DATE: OCT 28 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11053

Reg. Dist. No. 1098134

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
c. LENGTH OF STAY IN 1b: 3 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo's Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs x2
d. STREET ADDRESS: 10- Armand Ave., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle — Last APPICH

4. DATE OF DEATH: Month Oct. — Day 9th. — Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 20- 1877
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Firm
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Appich
14. MOTHER'S MAIDEN NAME: Louise Ermold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Furling B. Appich — Address: 10-Armand Ave., S. E. Wash. 23, DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive failure, R & Lft — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Myocardial heart disease — 2 years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1956, to Oct 9, 1957, that I last saw the deceased alive on October 9, 1957, and that death occurred at 4-40 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest E Cornelsen M.D.
ADDRESS (Street, city or town, state): 4400- Bowen Road S.E. Washington 27, D.C.
DATE SIGNED: Oct. 9th. 1957
PHYSICIAN'S NAME (Type): ERNEST E. CORNELSEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 11- 57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros.
ADDRESS: 1661 Good Hope Road SE Washington 20, D.C.
24a. REC'D BY REGISTRAR DATE: OCT 11 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10991

CERTIFICATE OF DEATH

10982 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 30 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landham
d. STREET ADDRESS 6031 Naval Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Samuel Middle Daniel Last Arnold

4. DATE OF DEATH Month Oct. Day 29 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/11/1900
9. AGE (In years last birthday) 56 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer Pressman
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt
11. BIRTHPLACE (State or foreign country) Great Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Wife Address Evelyn M. Arnold - Landham, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 hrs
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 29, 1957 to Oct 29, 1957 that I last saw the deceased alive on Oct 29, 1957 and that death occurred at 7:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Norman Donat Comeau M.D. ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 10/29/57

PHYSICIAN'S NAME (Type) Norman Donat Comeau Mt Rainier Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 11/1/57
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE NOV 4 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10992 **CERTIFICATE OF DEATH** Reg. Dist. No. 10983

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard ~~Prince Georges~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups 13 X 2.2
d. STREET ADDRESS: Annapolis Jct. Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lorraine — Middle Chaney — Last Arthur

4. DATE OF DEATH: Month Oct. — Day 29 — Year 1957

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 17 Sept. 1892

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: School Teacher

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William H. Chaney

14. MOTHER'S MAIDEN NAME: Hanna Thornton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Clarence Chaney, Address: Baltimore, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (g), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adrenal Failure.

154 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Tuberculosis & the Adrenal Gld.

DUE TO (c): Adeno carcinoma & the Sectum.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/18, 1957, to 10/29, 1957, that I last saw the deceased alive on 10/29, 1957, and that death occurred at 2,30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norman Donat Comeau M.D.

ADDRESS (Street, city or town, state): 3503 Penny ST

DATE SIGNED: 10/29/57

PHYSICIAN'S NAME (Type): NORMAN DONAT COMEAU MT RAINIER MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-1-57

22c. NAME OF CEMETERY OR CREMATORY: Asbury

22d. LOCATION (City, town, or county) (State): Jessups, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F.C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: NOV 1 57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10982 Item 5 Film C221 10-11-57 et

CERTIFICATE OF DEATH

10984

Reg. Dist. No. 24/5

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown Mt Rainier
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3319 Chauncey Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown, Mt. Rainier X2
d. STREET ADDRESS: 3319 Chauncey Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Barbara — Last: Bachman

4. DATE OF DEATH: Month: October — Day: 5th — Year: 1957

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1912

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Safeway Stores

11. BIRTHPLACE (State or foreign country): Jamestown, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Neal McKenney

14. MOTHER'S MAIDEN NAME: Josephine Brigman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 165-14-9981

17. INFORMANT: Harold L. Bachman — Address: ↑ above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: immediate
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): coronary insufficiency — 1 hour
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 3, 1954, to Oct 5, 1957, that I last saw the deceased alive on Oct 5, 1957, and that death occurred at 5:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank R. Shea M.D. — ADDRESS (Street, city or town, state): 4100-22nd St NE Wash DC — DATE SIGNED: 10/7/57

PHYSICIAN'S NAME (Type): FRANK R. SHEA, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/8/57

22c. NAME OF CEMETERY OR CREMATORY: Norwood Cem

22d. LOCATION (City, town, or county) (State): Philadelphia Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Walley's Funeral Home, Mt. Rainier Md. — ADDRESS: Sta.

24a. REC'D BY REGISTRAR DATE: OCT 9 1957

24b. REGISTRAR'S SIGNATURE: James Lowery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10993 **CERTIFICATE OF DEATH** 10985

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X O Ceder Hgts,
d. STREET ADDRESS: 914 65th Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alfonzo; Middle: ; Last: Bailey

4. DATE OF DEATH: Month: October; Day: 30; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 22, 57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: 2; Days: 8
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Lillian Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: 914 65th Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Congestion
DUE TO
(b): Malnutrition
DUE TO
(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

772.0

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 30, 19 57, to Oct. 30 19 57, that I last saw the deceased alive on Oct. 30, 19 57, and that death occurred at 6:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. ADDRESS (Street, city or town, state): 5301 Hamilton St. Hyattsville DATE SIGNED: 11/31/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11-4-57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Washington D C

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Washington & Sons ADDRESS: 467 N St. N. W.

24a. REC'D BY REGISTRAR DATE: NOV 6 '57

24b. REGISTRAR'S SIGNATURE: W. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

20772606XV4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the re... prior to burial, cremotion, or removol, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10994

10986

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 27 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park 14
d. STREET ADDRESS: Botler Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sam; Middle Strother; Last Bailey

4. DATE OF DEATH: Month October; Day 12; Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 20, 1886

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Bailey

14. MOTHER'S MAIDEN NAME: Sallie Dwyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT: Cova Bailey — Address: College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia, cause unknown — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pancytopenia, cause unknown — 1 yr
DUE TO
(c):

792x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1957, to Oct. 12, 1957, that I last saw the deceased alive on Oct. 12, 1957, and that death occurred at 6:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arnold Lear M.D.
ADDRESS (Street, city or town, state): 905 Sheridan St Hyattsville, Md
DATE SIGNED: 10-13-57

PHYSICIAN'S NAME (Type): Dr. Arnold Lear

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/16/57
22c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
22d. LOCATION (City, town, or county) (State): Culpeper Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons
ADDRESS: Hyattsville, Maryland.

24a. REC'D BY REGISTRAR DATE: OCT 14 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10995 Item 12 FilmG221 10-14-57 et 10987

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 27 D.C.
d. STREET ADDRESS: 2200 - 53rd. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES Middle Crawford Last BAILLIE
4. DATE OF DEATH: Month OCTOBER Day 7 Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 12, 1870
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at Home.
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Crawford
14. MOTHER'S MAIDEN NAME: Agnes McKendrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Allen S. Baillie 2200-53 Ave Wash. 27 D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho Pneumonia & pul. Cong & Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral Fractured rt femur
DUE TO
(c): Arteriosclerotic Heart Disease.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-1-57, 19____, to 10-7, 1957, that I last saw the deceased alive on 10-7-57 19____, and that death occurred at 9:40 AM from the causes and on the date stated above.
ACTUAL SIGNATURE: John T. Lyon M.D. ADDRESS (Street, city or town, state): 5441 Ft. Bennard Rd. 21 DC DATE SIGNED: 10/7/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/57
22c. NAME OF CEMETERY OR CREMATORY: Fort Steuben Estates
22d. LOCATION (City, town, or county) (State): Steubenville Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: E. W. Chambers ADDRESS: 517 11th St. S.E.
24a. REC'D BY REGISTRAR: OCT 9 57 DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10975

CERTIFICATE OF DEATH

10988 24-

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville Md
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3924 Oliver Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville Maryland
d. STREET ADDRESS: 3924 Oliver Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: R.; Last: Barr

4. DATE OF DEATH: Month: Oct; Day: 23; Year: 1957.

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 25, 1903

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James H. Moxley

14. MOTHER'S MAIDEN NAME: Dora Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Charles A Barr Sr Hyattsville, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis generalized Type, 175 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adenocarcinoma Of Ovary 1 Mos.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ascites

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 4, 1955 to Oct 22 1957, that I last saw the deceased alive on 10/22, 1957, and that death occurred at 11:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Hageage M.D. — ADDRESS (Street, city or town, state): 3217-38th Le — DATE SIGNED: 10-23-57

PHYSICIAN'S NAME (Type): George Hageage — Cottage City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/25/57

22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill

22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 28 1957

24b. REGISTRAR'S SIGNATURE: James Severy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10996 **CERTIFICATE OF DEATH** 10989

Reg. Dist. No. 246

1. PLACE OF DEATH
a. COUNTY: Pr Geo — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: as #1

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale

c. LENGTH OF STAY IN 1b: 4yr

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Same as #1

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6314 Tuckerman

d. STREET ADDRESS: Same as #1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ORLO Middle all Last BARTHOLOMEW

4. DATE OF DEATH: Month Oct Day 22 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5 June 1891

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Land developer

10b. KIND OF BUSINESS OR INDUSTRY: Engineer

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles L. Bartholomew

14. MOTHER'S MAIDEN NAME: Ella Henderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 149229548

17. INFORMANT — Address: Beulah A. Bartholomew Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

DUE TO (b): Hypertensive cardio-vascular 5yr +

DUE TO (c): disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1953 to Oct 1957, that I last saw the deceased alive on Sept 27 1957, and that death occurred at 5 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: W. L. Etienne — ADDRESS (Street, city or town, state): 4713 Baltimore Blvd — DATE SIGNED: 10/23/57

PHYSICIAN'S NAME (Type): W. L. ETIENNE — College Park, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 25 Oct 1957

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Maryland

24a. RECD. BY REGISTRAR DATE: OCT 24 1957

24b. REGISTRAR'S SIGNATURE: James E. Severe

EJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10990

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Prince Georges Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Park
d. STREET ADDRESS: 101 - 64th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Carrie May Middle A Last Bowler

4. DATE OF DEATH: Month Oct Day 16 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 18, 1880
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: James Hays
14. MOTHER'S MAIDEN NAME: Elizabeth Jenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Margaret Catharine Sally same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart fail
442X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovascular renal disease
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described above, held an Autapsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): James I. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Oct 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 18, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 18 57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be [illegible] for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11054 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10991
Reg. Dist. No. 773

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1007 Maple Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Bowie
d. STREET ADDRESS: 1007 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Leo — Last: Baumann
4. DATE OF DEATH: Month: October — Day: 4, — Year: 1957
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 2, 1909
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Ordinance
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Baumann
14. MOTHER'S MAIDEN NAME: Barbara Frieze

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: 579-48-6299
17. INFORMANT — Address: Dorothy E. Baumann; same address.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
442X
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John J. Maloney M.D.
EXAMINER'S NAME (Type) John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 4, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md.
24a. REC'D BY REGISTRAR — DATE: OCT 7 1957
24b. REGISTRAR'S SIGNATURE: Agnes Gaffney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be [illegible] for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10976 Item 7 Film C221 10-22-57 et

CERTIFICATE OF DEATH

10992

Reg. Dist. No. 715

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 25 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 6010 44th. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Wilson Last: Birch

4. DATE OF DEATH: Month: Oct. Day: 13th. Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/15/1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): D.C. School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Wilson

14. MOTHER'S MAIDEN NAME: Henrietta Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter
Address: Marian Birch 6010 44th.Ave., Hyattsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH: 10+ yrs
443X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): age 89

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 47, to 10-13, 19 57, that I last saw the deceased alive on 10-12, 19 57, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Waldo B. Moyers M.D. 3503 Perry St. Mt. Rainier Md 10-15-57

PHYSICIAN'S NAME (Type): Waldo B. Moyers

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/15/57

22c. NAME OF CEMETERY OR CREMATORY: Oakwood Cemetery

22d. LOCATION (City, town, or county) (State): Falls Church, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph F. Birch's Sons ADDRESS: 3034 M St., N.W., D.C.

24a. REC'D BY REGISTRAR DATE: OCT 15 1957

24b. REGISTRAR'S SIGNATURE: James Lowery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG222 11-4-57 et

11055

CERTIFICATE OF DEATH

10993

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forrestville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forrestville
d. STREET ADDRESS: 5294 Forrestville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Adelaide; Middle: D; Last: Bohrer

4. DATE OF DEATH: Month: Oct. Day: 24 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 15, 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alexander C.H. Darne

14. MOTHER'S MAIDEN NAME: Ruth Darby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Ruth D'Butts — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Hypertensive C.V.D. — INTERVAL BETWEEN ONSET AND DEATH
442 X
DUE TO
(b): Diabetes — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1945, to Aug 24, 1957 that I last saw the deceased alive on Aug 24, 1957, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William Brainin M.D. — ADDRESS (Street, city or town, state): 6144 Central Ave — DATE SIGNED: 10/24/57

PHYSICIAN'S NAME (Type): WM BRAININ — Capitol Hgts Md

22a. BURIAL, CREMATION, REMOVAL (Specify): 26 Oct 1957

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove Cem.

22d. LOCATION (City, town, or county) (State): Herndon, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 4th + Mass ave NE WASH. D.C.

24a. REC'D BY REGISTRAR DATE: OCT 29 1957

24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10998 — 10994

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 24 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 3817 Oglthorpe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Raymond Middle O. Last Boriff

4. DATE OF DEATH: Month 10 Day 9 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 Mar 1912

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DEPUTY Collector

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): SPARTA, MISSOURI

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM H. BORIFF

14. MOTHER'S MAIDEN NAME: SARAH A. WEAVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 499-14-0286

17. INFORMANT: WILLIAM H. BORIFF — Address 3817 Oglethorpe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carbuncle - left elbow — 1 week
DUE TO
(c): Marked disability due to old polio — 45 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-6, 1957, to 10-9, 1957, that I last saw the deceased alive on 10-9 1957, and that death occurred at 12:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.D. Bauer M.D.
ADDRESS (Street, city or town, state): 2513 Buckingham Rd Hyattsville Md.
DATE SIGNED: 10/9/57
PHYSICIAN'S NAME (Type): R. D. Bauer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Oct. 10, 1957

22c. NAME OF CEMETERY OR CREMATORY: Ohio Memorial Cemetery

22d. LOCATION (City, town, or county) (State): Ozark, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. E. Chambers Sr.
ADDRESS: Riverdale, Md.

24a. RECEIVED BY REGISTRAR DATE

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the record or prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11056

CERTIFICATE OF DEATH

10995

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 7 mos.,& 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 775 Columbia Rd., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: — Last: Braswell

4. DATE OF DEATH: Month: 10 — Day: 14 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/24/41

9. AGE (In years last birthday): 16 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charlie R. Braswell

14. MOTHER'S MAIDEN NAME: Mallie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Charlie R. Braswell
Address: 775 Columbia Rd., N.W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SUDDEN DEATH, POSTOPERATIVE, FOLLOWING RT. UPPER 002X — INTERVAL BETWEEN ONSET AND DEATH: 0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): LOBECTOMY & WEDGE RESECTION SUPERIOR SEGMENT
DUE TO (c): RT. LOWER LOBE 9/30/57, CAUSE UNDET.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY TUBERCULOSIS 7 MOS. (REASON FOR SURGERY)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/1, 19 57, to 10/14, 19 57, that I last saw the deceased alive on 10/14, 1957, and that death occurred at 9:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss M.D.

ADDRESS (Street, city or town, state): Glenn Dale Hospital

DATE SIGNED: 10/14/57

PHYSICIAN'S NAME (Type): Moe Weiss, M.D. Glenn Dale, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 10/15/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l.Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: B. F. Taylor Funeral Home

ADDRESS: 1702-7/12th

24a. REC'D BY REGISTRAR DATE: OCT 17 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10996

11057

Reg. Dist. No. 243

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville
c. LENGTH OF STAY IN 1b 45 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mill Branch Road

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville X1
d. STREET ADDRESS Mill Branch Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Heinrich Middle: Brattner Last:
4. DATE OF DEATH Month: Oct Day: 22 Year: 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 9, 1876
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Heinrich Brattner
14. MOTHER'S MAIDEN NAME: Wreagens Brattner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Henry John Brattner, same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive heart failure
442 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular renal Disease
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James H Boyd M.D.
EXAMINER'S NAME (Type) James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12-23-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/25/57
22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem.
22d. LOCATION (City, town, or county) (State): White Marsh, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Upper Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: NOV 1 1957
24b. REGISTRAR'S SIGNATURE: J. W. Hopkins EJ

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10997

1105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tanyard Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor
d. STREET ADDRESS Tanyard Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Marvin Middle Leo Last Brown

4. DATE OF DEATH Month Oct Day 24 Year 1957

5. SEX male

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Aug 16, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR Months 2 Days 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Edward Brown

14. MOTHER'S MAIDEN NAME Mary Lucille Makle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address John E. Brown, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

491X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) JAMES I. BOYD DATE SIGNED Oct 24, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial **22b.** DATE THEREOF Oct 24, 1957 **22c.** NAME OF CEMETERY OR CREMATORY St Peters **22d.** LOCATION (City, town, or county) (State) Waldorf, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hunt Funeral Home Waldorf, Md

24a. REC'D BY REGISTRAR DATE 10/25/57 **24b.** REGISTRAR'S SIGNATURE Julia H Lancaster

OCT 28 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S) 5M 9/55

2077254XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10999

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10998 3/24

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights
c. LENGTH OF STAY IN 1b 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 405-58th Street

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights
d. STREET ADDRESS 405-58th
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mary Middle Emma Last Brown
4. DATE OF DEATH Month Oct Day 29 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH March 14, 1885
9. AGE (In years last birthday) 72 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Clifton Hardy
14. MOTHER'S MAIDEN NAME Margaret Alice Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Address William Roy Brown Kenmar #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

(b) Cardiovascular renal disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James T. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED Oct 29, 1957

EXAMINER'S NAME (Type) James T. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-1-57
22c. NAME OF CEMETERY OR CREMATORY Washington, Nat.
22d. LOCATION (City, town, or county) (State) Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.
ADDRESS Washington, D.C.

24a. REC'D BY REGISTRAR DATE NOV 1 '57
24b. REGISTRAR'S SIGNATURE Carrie Compton

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10999

,11059

CERTIFICATE OF DEATH

Reg. Dist. No. 14r

1. PLACE OF DEATH
a. COUNTY Prince Georges' MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie

c. LENGTH OF STAY IN 1b 18 Mos.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x1 Ritchie

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's County Rest Home

d. STREET ADDRESS D'Arcy Road

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	James	--	Butler		October	17,	1957.

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Col.	[ ] [X] [ ] [ ]	Unknown	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Emplyd Gardiner	Gen. Farming	U. S. A.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	---	---	Alfred H. Smith-	Blythwood Farm, Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Congestive Cardiac failure	1 day
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Chronic myocarditis arteriosclerotic	1 yr
DUE TO (c)	General Arteriosclerosis	Unknown

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work [ ] Not while at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
—	— 19		—	

21. I certify that I attended the deceased from June 1, 1956 to Oct 17, 1957, that I last saw the deceased alive on Oct 16, 1957, and that death occurred at 4 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Paul C Van Natta M.D. ADDRESS (Street, city or town, state) 5440 Silver Hill Road, Suitland, Maryland. DATE SIGNED 10/17/57:

PHYSICIAN'S NAME (Type) Paul C. Van Natta, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/19/57	Lincoln Memorial Cem:	Suitland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Ritchie Bros. Funeral Home	Upper Marlboro, Md.	OCT 21 1957	Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10983

11000

Reg. Dist. No. 245

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Rainier
c. LENGTH OF STAY IN 1b: 34 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3813 33rd Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Mount Rainier
d. STREET ADDRESS: 1 3813 33rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Susan — Last: Camfield

4. DATE OF DEATH: Month: October — Day: 5 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 3, 1881

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas Marson

14. MOTHER'S MAIDEN NAME: Margaret Krock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thornton J. Camfield; Address: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH:
443X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial asthma.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 5, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/8/57
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home Inc.
ADDRESS: Mt. Rainier Md.

24a. RECEIVED BY REGISTRAR DATE: OCT 9 1957
24b. REGISTRAR'S SIGNATURE: James Devereux

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11000

CERTIFICATE OF DEATH

11001

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47 x-3
d. STREET ADDRESS: 1917- 17th. Street S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Prince George's General Hospital

3. NAME OF DECEASED (Type or print): First JOSEPH; Middle; Last CAPONITI

4. DATE OF DEATH: Month Oct. Day 3rd. Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 10- 1894

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Natale Caponiti

14. MOTHER'S MAIDEN NAME: Domenica Cascio

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Address): James G. Caponiti 1624- Good Hope Rd. S. E. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Necrotizing Papilitis
DUE TO
(b): Etiology Unknown
DUE TO
(c):

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/26 19 57 to 10/3 19 57 that I last saw the deceased alive an 10/3/57 19 , and that death occurred at 4 20 P M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Leon Levitsky M.D. — ADDRESS (Street, city or town, state): 3408 Rhode Island — DATE SIGNED: 10/3/57

PHYSICIAN'S NAME (Type): Leon R Levitsky — MT RAINIER, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 7th 1957

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Brothers — ADDRESS: 1661- Good Hope Road SE Washington, DC.

24a. REC'D BY REGISTRAR — DATE: OCT 7 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11001 — Reg. Dist. No. 11002

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capitol Heights
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6211- Kingston ave

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Seat Pleasant
d. STREET ADDRESS: 64th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Bernard — Last: Carrich
4. DATE OF DEATH: Month: Oct — Day: 3 — Year: 1957
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Sept 7 1893
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Carrich
14. MOTHER'S MAIDEN NAME: Anny Hood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): WW — (If yes, give war or dates of service): I
16. SOCIAL SECURITY NO.: 579-10-4980
17. INFORMANT: Rose Mc Donald — Address: same as # 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypostatic Bronchopneumonia
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D.: James L Boyd
EXAMINER'S NAME (Type): James L. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-4-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-8-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co
ADDRESS: Washington, D.C.
24a. REC'D BY REGISTRAR / DATE: OCT 7 19
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11002 — Reg. Dist. No. 11003

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Forestville,
d. STREET ADDRESS: 8101 Park Blvd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: Cave

4. DATE OF DEATH: Month: October — Day: 10, — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/10/57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours: 1 — Min.: 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William David Cave

14. MOTHER'S MAIDEN NAME: Erna ~~A~~smussen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr 15 min
762.5
DUE TO
(b): Prematurity — 1 hr 15 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/10/57, 19____, to 10/10/____, 19 57, that I last saw the deceased alive on 10/10/____, 19 57, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R B Sasscer M.D. — ADDRESS (Street, city or town, state): Upper Marlboro, Md — DATE SIGNED: Oct 10-57

PHYSICIAN'S NAME (Type): R. B. Sasscer

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10/29/57

22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital, Cheverly, Md.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Wenn, Jr., Administrator.

ADDRESS:

24a. REC'D BY REGISTRAR DATE: NOV 1 '57

24b. REGISTRAR'S SIGNATURE:

2077253XM0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11004

11003 **CERTIFICATE OF DEATH** Reg. Dist. No. 245

1. PLACE OF DEATH
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 College Park
   d. STREET ADDRESS: #5 5th St. Cherry Hill Trailer Court
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

76

3. NAME OF DECEASED (Type or print): First: MARY Middle: JANE Last: CLARK

4. DATE OF DEATH: Month 10 Day 28 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6. 1873

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Gouverneur, New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ambrose Cunningham

14. MOTHER'S MAIDEN NAME: Helen Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Mabel C. Jewell, Address: (same as #2)

0

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	12 hr.
DUE TO (b)	Arteriosclerosis	10 yrs.
DUE TO (c)	Hypertension	15 yrs.

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-1, 1955 to 10-28, 1957 that I last saw the deceased alive on 10-28, 1957, and that death occurred at 9:55 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R D Baker M.D. ADDRESS (Street, city or town, state): 2513 Buckledge Rd. DATE SIGNED

1

PHYSICIAN'S NAME (Type): R. D. BAKER, M.D. Adelphi Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Transit Burial

22b. DATE THEREOF: Oct. 31, 1957

22c. NAME OF CEMETERY OR CREMATORY: Antwerp Cemetery

22d. LOCATION (City, town, or county) (State): Antwerp New York

23. FUNERAL DIRECTOR'S SIGNATURE: J. [illegible] Gawler

ADDRESS: 254 CARROLL St NW. WASH. D.C.

24a. REC'D BY REGISTRAR DATE: OCT 30 1957

24b. REGISTRAR'S SIGNATURE: James Severy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11006

CERTIFICATE OF DEATH

11060 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 9 mos., & 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X-3
d. STREET ADDRESS: 1814 Que St., S.E., #10
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Bessie	J.	Cleary		10	24	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		12/11/1900	56 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bindery Operator	Columbia Planograph Co., 52 L. St., N.E.	Washington, D. C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Mann	Nettie Kelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	Unknown	Decedent	—

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis due to arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): diabetes mellitus — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

260X

Pneumonia left lung; etiology undetermined; pulmonary tuberculosis;

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work ☐ Not white at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 1/21, 1957, to 10/24, 1957, that I last saw the deceased alive on 10/24/57, 19—, and that death occurred at 4:10 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss, M.D. — ADDRESS (Street, city or town, state): Glenn Dale Hospital — DATE SIGNED: 10/24/57

PHYSICIAN'S NAME (Type): Moe Weiss, M. D. — Glenn Dale, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 28, 1957	Glenwood Cems.	Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Rees Funeral Home, C. M. Frame — ADDRESS: Cheverly, Md. 2847 Wilson Blvd

24a. REC'D BY REGISTRAR DATE: OCT 28 '57 — 24b. REGISTRAR'S SIGNATURE: W. Trench

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11061

CERTIFICATE OF DEATH

11007
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hill Crest Hights
c. LENGTH OF STAY IN 1b: 5 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hill Crest Hights
d. STREET ADDRESS: 5800 Belmore Place
e. IS RESIDENCE ON A FARM? YES [redacted] NO

3. NAME OF DECEASED (Type or print): First Russell Middle V. Last Coleman

4. DATE OF DEATH: Month Oct Day 28, Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 29 1896

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Gun Factory
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew J. Coleman

14. MOTHER'S MAIDEN NAME: Emma A. Jollette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Evelyn Coleman — Address: Res

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 months
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-20-, 1953 to 10-28, 1957 that I last saw the deceased alive on 10-28-, 1957, and that death occurred at 6 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David Gordon, M.D. — ADDRESS (Street, city or town, state): 5731 23rd Parkway SE Washington DC — DATE SIGNED: 10-28-57

PHYSICIAN'S NAME (Type): DAVID S. GORDON, M.D. 5731 23rd PARKWAY S.E. Washington, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 10-31-57 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill — 22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. William Lee Son — ADDRESS: 300-4 St S.W. D.C.

24a. REC'D BY REGISTRAR DATE: OCT 30 '57 — 24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11062

CERTIFICATE OF DEATH

Reg. Dist. No. 11008

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEAT PLEASANT
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M D — b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 SEAT PLEASANT
d. STREET ADDRESS: 6446 ROLLINS AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHARLOTTE — Middle E — Last COMPHER

4. DATE OF DEATH: Month Oct — Day 1 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-11-1900
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): New York N Y
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles Correll
14. MOTHER'S MAIDEN NAME: Freda Siebert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles C Compher — Address: 6446 Rollins Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.
420.0
DUE TO (b): Severe Hypertensive Arteriosclerotic Heart Disease — 12 Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Very Severe hypertensive 300+/140.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952 Jan 19— to 10/1/57, 19—, that I last saw the deceased alive on 10/1/57, 19—, and that death occurred at —M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sidney W. Lowry M.D. — ADDRESS (Street, city or town, state): 7200 Marlboro Pike S.E. — DATE SIGNED: 10/1/57
PHYSICIAN'S NAME (Type): SIDNEY W. LOWRY M.D. District Heights, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-4-57
22c. NAME OF CEMETERY OR CREMATORY: ADDISON CHAPEL
22d. LOCATION (City, town, or county) (State): SEAT PLEASANT MD

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Ga Ave NW
24a. REC'D BY REGISTRAR DATE: OCT 7 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11009/00
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WALDORF MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ACCOKEEK 08 x 0.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VERTIE SUSIE — Middle VERA. — Last COOK

4. DATE OF DEATH: Month OCTOBER — Day 22 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV 5 1914

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALBERT JENKIN

14. MOTHER'S MAIDEN NAME: SUSIE BERRY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: WILLIAM COOK — Address: ACCOKEEK MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SURGICAL SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

825X

DUE TO (b): COMPOUND FRACTURE, RIGHT FEMUR

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AUTO ACCIDENT

20c. TIME OF INJURY: Month, Day, Year — Hour 5:30 p. m. OCT. 22 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HIGHWAY

20f. (City or town) (County) (State): P.G.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: V B Dettor M.D.

EXAMINER'S NAME (Type): V. B. DETTOR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 23 Oct. 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10-25-57
22c. NAME OF CEMETERY OR CREMATORY: Christ Church CEM.
22d. LOCATION (City, town, or county) (State): ACCOKEEK Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hewitt Funeral Home
ADDRESS: WALDORF Md.

24a. REC'D BY REGISTRAR DATE: 10/25/57
24b. REGISTRAR'S SIGNATURE: Julia H Penny

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11004 — Reg. Dist. No. 11010

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 41 Laurel
d. STREET ADDRESS: 321 Compton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Kathy — Middle: Ann — Last: Cooper
4. DATE OF DEATH: Month: October — Day: 1, — Year: 19 57
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 10, 1957
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days: 7 weeks — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **********
10b. KIND OF BUSINESS OR INDUSTRY: **********
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Cooper
14. MOTHER'S MAIDEN NAME: Carol Crayne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Robert Cooper; same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): John T. Maloney, M.D. — October 1, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 3 1957
22c. NAME OF CEMETERY OR CREMATORY: Lawn Hill
22d. LOCATION (City, town, or county) (State): Laurel P.G. Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Arthur Rona Comp Laurel Md
24a. REC'D BY REGISTRAR — DATE: OCT 9 57
24b. REGISTRAR'S SIGNATURE

207223XV4

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11005 11011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 245

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 2906 Rueckart Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Archie — Middle: Grayson — Last: Crummitt

4. DATE OF DEATH: Month: October — Day: 13 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1898

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10b. KIND OF BUSINESS OR INDUSTRY: B.&O. Rauilroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert W. Crummitt

14. MOTHER'S MAIDEN NAME: Mary Creager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-10-0635

17. INFORMANT — Address: Elizabeth Crummitt; same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John J Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John T. Maloney, M.D.
DATE SIGNED: October 13, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-17-57
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: M. R. Etchison & Son, Frederick, Maryland

24a. REC'D BY REGISTRAR — DATE: OCT 15 1957

24b. REGISTRAR'S SIGNATURE: Jamesheverey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11006

CERTIFICATE OF DEATH

11012
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Prince George — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md. — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 41 Laurel
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS: 308 Main St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Myrtle		Curley	Oct.	20,	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Sept. 26, 1874	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Williamsport, Md	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Philip P. Castle	Elmira Jane Puffengarger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	6 - - -	Mrs. Regina Hobbs St. Petersburg, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 4 d

420.1

DUE TO (b) Hypertension —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardio-Vascular Dis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 49 to 10/20, 19 57, that I last saw the deceased alive on 10/20, 19 57, and that death occurred at 5:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE B P Warren M.D. ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 10/21/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 23, 1957	Ivy Hill	Laurel, Md. P. G. Co.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
[illegible]	Laurel Md	OCT 25 '57	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11064

11013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BARDBERRY PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 4734 BROMLEY AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRADBERRY PARK x2
d. STREET ADDRESS: 4734 BROMLEY AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BERTHA Middle: V. Lost: DECKER

4. DATE OF DEATH: Month: OCTOBER Day: 25 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-26-1881

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Wright

14. MOTHER'S MAIDEN NAME: Eva Stubbs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 064-14-3904

17. INFORMANT: Willard Wang — Address: Bradbury Park Md

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
331X
DUE TO
(b): Cerebral Arteriosclerosis
DUE TO
(c):

Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 20 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1957 to Oct 25, 1957, that I last saw the deceased alive on Oct 25, 1957, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. H. Thibadeau M.D.
ADDRESS (Street, city or town, state): 3112 - A1A AVE. SE.
DATE SIGNED:

PHYSICIAN'S NAME (Type): D. H. THIBADEAU

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-29-57
22c. NAME OF CEMETERY OR CREMATORY: East Bloomfield Cem.
22d. LOCATION (City, town, or county) (State): East Bloomfield N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee — Wash. D. C.
ADDRESS:

24a. REC'D BY REGISTRAR DATE: OCT 29 '57
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1111065 — Reg. Dist. No. 11014

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cedon Hill
c. LENGTH OF STAY IN 1b: 54 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6650 Tucker Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x1 Cedon Hill
d. STREET ADDRESS: 16650 Tucker Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Edmonia — Last: Delozier
4. DATE OF DEATH: Month: Oct — Day: 24 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: June 20, 1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Walter Marr
14. MOTHER'S MAIDEN NAME: Jennie Marr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Annie E Worrell — Address: 2020 Atlantic Rd S W Wash 22, D C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cardiovascular renal disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED: Oct 24, 1957
EXAMINER'S NAME (Type): JAMES I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 26-57
22c. NAME OF CEMETERY OR CREMATORY: St Ignatius
22d. LOCATION (City, town, or county) (State): Cedon Hill, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Brothers — ADDRESS: 1661 Good Hope Rd S E Wash 20 D C
24a. REC'D BY REGISTRAR — DATE: OCT 28 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G222, 11/1/57 fcy

11015

CERTIFICATE OF DEATH

10977

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): HYATTSVILLE MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: PRINCE GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE MD.
d. STREET ADDRESS: 6736 DARBEY RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First JOHN Middle JOSEPH Last DOLAN

4. DATE OF DEATH: Month October Day 27, Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 7-8-76

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): IRELAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MICHAEL DOLAN

14. MOTHER'S MAIDEN NAME: MARY ROONEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MARY BENTON Address: 6736 DARBEY RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 min
331 X
DUE TO
(b): Arteriosclerosis — 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hemiparesis from previous stroke 15 years ago

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1957, to 25 Oct, 1957, that I last saw the deceased alive on 25 Oct, 1957, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Kehoe M.D.

ADDRESS (Street, city or town, state): DATE SIGNED

PHYSICIAN'S NAME (Type): JOHN KEHOE, M.D.
3404 CHEVERLY AVE.
CHEVERLY, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-30-57

22c. NAME OF CEMETERY OR CREMATORY: Colvar Cemetery

22d. LOCATION (City, town, or county) (State): New York NY

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Baltimore Blvd

24a. REC'D BY REGISTRAR DATE: OCT 26 1957

24b. REGISTRAR'S SIGNATURE: James Sevenson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11066

CERTIFICATE OF DEATH

11016

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
c. LENGTH OF STAY IN 1b: 3 yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Forestville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box. 284--Westphalia Rd.
d. STREET ADDRESS: 1 Box 284 Westphalia Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah Middle: O. Last: Douglass
4. DATE OF DEATH: Month: Oct. Day: 20th. Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 14, 1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Phillip Collins
14. MOTHER'S MAIDEN NAME: Mary E. Ensor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lillian O. Anderson Address: Box. 286 Westphalia Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): C V A - Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH:
1999
DUE TO
(b): Cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): A S H D - Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/19, 1957, to 10/20, 1957, that I last saw the deceased alive on 10/20, 1957, and that death occurred at 11.45 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: David R. Lenarduzzi M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: Oct. 21st. 1957

PHYSICIAN'S NAME (Type): David R. Lenarduzzi 2901-Fairlawn Ave., SE Hillcrest Hgts, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 23-1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros.
ADDRESS: 1661--Good Hope Rd., SE Washington, DC
24a. REC'D BY REGISTRAR DATE: Oct 23 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11007 (typed) 11017 (Reg. Dist. No.)

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Seat Pleasant~~/ Cheverly
c. LENGTH OF STAY IN 1b: 22 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat pleasant Md. x2
d. STREET ADDRESS: 7013 D. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): ~~Duchene~~/ First: Viola Middle: May Last: Duchene

4. DATE OF DEATH: Month: Oct Day: 21 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/18/03

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Austine A. Adams

14. MOTHER'S MAIDEN NAME: Grace Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: Yes/unknown

17. INFORMANT: Mr. August A. Duchene. Address: 7013 D St. S E Seat Pleasant, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b): Hypertension CVR Disease — 4yr,
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 15, 1957 to Oct 21, 1957, that I last saw the deceased alive on Oct 21, 1957, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William Brainin M.D. — ADDRESS (Street, city or town, state): 612 Central Ave — DATE SIGNED: 10/24/57

PHYSICIAN'S NAME (Type): WM BRAININ — Capitol Hgts Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 25, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: 517-11th St. S.E.

24a. REC'D BY REGISTRAR DATE: OCT 24 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the re[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11018

10974

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince George's — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, Md

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4720 Ruatan Street,.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, Md.

d. STREET ADDRESS: 4720 Ruatan Street,.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gertrude Middle T. Last Dyer

4. DATE OF DEATH: Month October Day 25, Year 19 57.

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 20, 1884

9. AGE (In years ~~last~~ birthday) 73 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Katherine E. Dyer Address: College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 20

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertensive Cardio - Vascular Dis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1949, 19___, to Oct, 19 57, that I last saw the deceased alive on October 19 57, and that death occurred at 12 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE W. L. Etienne M.D. — ADDRESS (Street, city or town, state) 4713 - Tennyson Rd — DATE SIGNED

PHYSICIAN'S NAME (Type) W. L. ETIENNE College Park, Md 10-26-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 28, 1957

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Maryland.

24a. REC'D BY REGISTRAR DATE OCT 29 '57

24b. REGISTRAR'S SIGNATURE W. L. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the re... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11008 — 11019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGE'S GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 TAKOMA PARK
d. STREET ADDRESS: 7413 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: DORA — Middle: C — Last: FERRIER

4. DATE OF DEATH: Month: 10 — Day: 19 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 Oct 1917

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months: — Days: 44
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John N. Ours

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Joseph G. Ferrier (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 1 month.
174X
DUE TO (b): Pelvic Carcinomatosis — 4 months.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Adenocarcinoma Uterus. — 4 months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 12, 19 57, to October 19, 19 57, that I last saw the deceased alive on October 19, 19 57, and that death occurred at 7:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Octavio Gonzalez Co. M.D. — ADDRESS (Street, city or town, state): Prince George's General Hospital — DATE SIGNED: 10-22-57

PHYSICIAN'S NAME (Type): Dr. George H McLain

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 23, 1957
22c. NAME OF CEMETERY OR CREMATORY: St. Lincoln Cemetery
22d. LOCATION (City, town, or county): P. George Co. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. Arthur Walters, 254 Carroll St NW. DC.

24a. REC'D BY REGISTRAR DATE: OCT 22 57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11009 **CERTIFICATE OF DEATH** 11020

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Washington 21
d. STREET ADDRESS: 9199 Central Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: Fisher

4. DATE OF DEATH: Month: Oct. — Day: 21 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 Apr. 1907

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher

10b. KIND OF BUSINESS OR INDUSTRY: Southern Hotel Supply

11. BIRTHPLACE (State or foreign country): Washington, D.C

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Fisher

14. MOTHER'S MAIDEN NAME: Emily Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 578-09-3505

17. INFORMANT: Mrs. Jessie I. Fisher — Address: 9199 Central Ave, Capitol Hgts. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
(b): arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20, 1957 to 10/24, 1957, that I last saw the deceased alive on 10/21, 1957, and that death occurred at 2.00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ronald Fleischer M.D. — ADDRESS (Street, city or town, state): RONALD S FLEISCHER — DATE SIGNED

PHYSICIAN'S NAME (Type): 4432 QUEENS CHAPEL Rd HYATTSVILLE, MD 10/24/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/25/57

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co — ADDRESS: 517-11th St. S. E.

24a. REC'D BY REGISTRAR DATE: OCT 24 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director. page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the re[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11010

CERTIFICATE OF DEATH

11022

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 16 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Brentwood, Md.
d. STREET ADDRESS: 4500 Banner St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: Ford

4. DATE OF DEATH: Month: October — Day: 23 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-2- 1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Norbeck, Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James M. Ford

14. MOTHER'S MAIDEN NAME: Althea Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Amanda Bond Address: Silver Spring, Md. Route # 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 Y.

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardio-vascular renal disease — years
DUE TO (c): Postal Carcinoma — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-8, 1957, to 10-23, 1957, that I last saw the deceased alive on 10/23, 1957, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): RONALD S FLEISCHER

DATE SIGNED

PHYSICIAN'S NAME (Type): V432 QUEENS CHAPEL Rd HYATTSVILLE MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-27-57

22c. NAME OF CEMETERY OR CREMATORY: Norbeck

22d. LOCATION (City, town, or county) (State): Montgomery Co

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L Snowden

ADDRESS: Rockville

24a. REC'D BY REGISTRAR DATE: OCT 31 57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the reg[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11023

11067

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro Dist.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt 301

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Rt 301
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Laurence — Middle: Benjamin — Last: Ford Jr
4. DATE OF DEATH: Month: Oct — Day: 18 — Year: 19 57

5. SEX: male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 3 1957
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 15
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Laurence Benjamin Ford Jr
14. MOTHER'S MAIDEN NAME: Mary Clayton Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary E. Hamilton, same as 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxemia
DUE TO (b): Bronchopneumonia
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7630
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Boyd M.D.
EXAMINER'S NAME (Type): James T. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 10-18-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/19/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
22d. LOCATION (City, town, or county) (State): Upper Marlboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ritchie Bros. Upper Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: OCT 22 '57
24b. REGISTRAR'S SIGNATURE: [signature]

2077268XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11024

11011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ashville 70 x-3
d. STREET ADDRESS: 114 Ashland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry — Middle Daniel — Last Frye

4. DATE OF DEATH: Month October — Day 6 — Year 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/21/35.

9. AGE (In years last birthday): 21 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Asheville, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lee W. Frye

14. MOTHER'S MAIDEN NAME: Opal Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Mrs Opal Rutherford Asheville N.C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Fracture of the base of the skull
DUE TO (c): Compound comminuted fracture of the left tibia and fibula

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that was in a collison with another car

20c. TIME OF INJURY: Hour 12:58 a.m. — Month, Day, Year 10/6 57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) (County) (State): Capital Heights P.G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: October 6, 1957

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation — 22b. DATE THEREOF: 10/7/57

22c. NAME OF CEMETERY OR CREMATORY: Asheville

22d. LOCATION (City, town, or county) (State): North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: . Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 8 '57

24b. REGISTRAR'S SIGNATURE

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11025
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 1707 Columbia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruby — Middle: Ethel — Last: Frye

4. DATE OF DEATH: Month: Oct. — Day: 23rd — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 25 Jan. 1890

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mayola F. Adams (Daughter) — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

442 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 23, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 27 Oct 1957
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): Henderson Tenn.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 25 '57

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11013

Reg. Dist. No. 11026

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 min.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Croome
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Galloway — Middle: Baby — Last: Boy

4. DATE OF DEATH: Month: 22 Oct. — Day: 1957 — Year: 19

5. SEX: Male

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 22 Oct. 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 8

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Hagen

14. MOTHER'S MAIDEN NAME: Beatrice Baskerville

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: mother - as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: Im birth
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Prematurity — DUE TO — Im Birth
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 22, 1957, to Oct. 22, 1957, that I last saw the deceased alive on Oct. 22, 1957, and that death occurred at 8.45 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton St., Hyatts, Md — DATE SIGNED: 10/23/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): cremation

22b. DATE THEREOF: 10/29/57

22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital, Cheverly, Md.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Harry W. Penn, Jr., Administrator.

24a. REC'D BY REGISTRAR DATE: NOV 1 57

24b. REGISTRAR'S SIGNATURE

2077379 XVD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10984

CERTIFICATE OF DEATH

11027

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 608 ETHAN ALLEN AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 608 ETHAN ALLEN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PATRICK — Middle JOSEPH — Last GLEASON

4. DATE OF DEATH: Month OCTOBER — Day 31 — Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 18, 1878
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRADE FOREMAN, SANITATION DIV., D.C. GOV'T.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: MARTIN GLEASON
14. MOTHER'S MAIDEN NAME: KATHERINE SCOTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: WM. PAUL GLEASON, 2112 DEXTER AVE., SILVER SPRING

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Respiratory Failure	
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. (b) DUE TO	Cardiac Failure; Cardiac Asthma.	2 weeks
(c)	Arteriosclerotic Heart Disease	20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	Overweight	

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1937, 19____, to 1957, 19____, that I last saw the deceased alive on 10/30/57, 19____, and that death occurred at 11:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Allen E. Lee M.D.
ADDRESS (Street, city or town, state): 2000 P St., N. W., Washington, DC
DATE SIGNED: 11/2/57

PHYSICIAN'S NAME (Type): ALLEN E. LEE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: NOV. 5, 1957
22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE'S CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: NOV 6 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the re[illegible] or prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11014 7

11028
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Cedar Hghts. Md
d. STREET ADDRESS: 904 64th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Gorham — Last:

4. DATE OF DEATH: Month: Oct. — Day: 29 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Carter

14. MOTHER'S MAIDEN NAME: Malinda Gooseberry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Arthur Carter — Address: 4507 R.I. Ave. N.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden
332x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cebro-vascular Arteriosclerosis — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-27, 19 57 to 10-29, 19 57, that I last saw the deceased alive on 10-29, 19 57, and that death occurred at 11:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R Rudolf Fleischer M.D. — ADDRESS (Street, city or town, state): 5432 QUEENS CHAPEL Rd — DATE SIGNED

PHYSICIAN'S NAME (Type): RONALD S. FLEISCHER HYATTSVILLE, Md 10/30/57

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11-2-57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Washington D.C

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Washington & Son — ADDRESS: 467 N St. NW

24a. REC'D BY REGISTRAR DATE: NOV 6 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11015

CERTIFICATE OF DEATH

Item 8 Film 222 11-21-57 et

11029

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MD
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16
d. STREET ADDRESS 3413 R.I. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First James Middle Hammett Last
4. DATE OF DEATH Month October Day 28 Year 19 57
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 1, 1884
9. AGE (In years last birthday) 73 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY self employed
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Lucy E. Hammett Address Mt. Rainier, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary cong & edema
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Infarction L.V. septum
DUE TO
(c) Arteriosclerotic Hrt disease.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/27, 19 57, to 10/28, 19 57, that I last saw the deceased alive on 10/28/57, 19 , and that death occurred at 1:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Leon R Levitsky M.D. ADDRESS (Street, city or town, state) 3409 Rhode Island DATE SIGNED 10/28/57
PHYSICIAN'S NAME (Type) Leon R. Levitsky Mt Rainier, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/31/57
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11016

CERTIFICATE OF DEATH

11030

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 hr. 45 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Park, Md.
d. STREET ADDRESS: 1114 Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Flora — Middle: Elaine — Last: Harrod

4. DATE OF DEATH: Month: October — Day: 20 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-19-57

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: 9 Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George Proctor

14. MOTHER'S MAIDEN NAME: Flora Ann Harrod

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Adelle Trower — Address: Landover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
754.4
DUE TO
(b): Congenital Heart Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs. from birth.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 491x

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. ft. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct-20, 1957, to Oct-20, 1957, that I last saw the deceased alive on Oct-20, 1957, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jolund Perkins M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton St., Hyattsville — DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 10-23-57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Wash. DC

23. FUNERAL DIRECTOR'S SIGNATURE: Bowie & Matthews — ADDRESS: 3619-14th St NW

24a. REC'D BY REGISTRAR — DATE: OCT 28 '57

24b. REGISTRAR'S SIGNATURE: Dielmann

2077215 X V3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11031

11017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton x2
d. STREET ADDRESS: Box 1189 /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert — Middle — Last Hawkins
4. DATE OF DEATH: Month Oct — Day 31 — Year 1957

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: [illegible]
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Prince George Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Bruce Hawkins
14. MOTHER'S MAIDEN NAME: Mary Pinkney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-05-0550
17. INFORMANT: William Pinkney (Brother) Address: 4420 Campbell Dr Dupont Hghts-Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): C.V. A.
DUE TO (b): Hypertensive Arteriosclerotic Hrt dis
DUE TO (c):

420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-25, 19 57, to 10-31, 19 57, that I last saw the deceased alive on 10-30, 19 57, and that death occurred at 9:25 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ronald Fleischer by M.D.
ADDRESS (Street, city or town, state): 7732 Queens Chapel Rd
DATE SIGNED: 11/1/57
PHYSICIAN'S NAME (Type): RONALD S FLEISCHER by Hattie Lee

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov-4-1957
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): 4611-Benning Rd. S.E. Wash. DC

23. FUNERAL DIRECTOR'S SIGNATURE: William Spangler
ADDRESS: 524-8-St N.E. Wash D.C. 2
24a. REC'D BY REGISTRAR DATE: NOV 4 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11018

CERTIFICATE OF DEATH

11032

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b: 2dm. 8-9-53
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LAUREL SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D. C. 47X-3
d. STREET ADDRESS: 6918 6th STREET N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLLIE — Middle WEBB — Last HOPKINS

4. DATE OF DEATH: Month 10 — Day 30 — Year 1957

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 23-1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: ÷

11. BIRTHPLACE (State or foreign country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas WEBB

14. MOTHER'S MAIDEN NAME: DRUCILLA Riggins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: HOSPITAL RECORDS — Address: LAUREL SANITARIUM

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess in mouth — INTERVAL BETWEEN ONSET AND DEATH: 4 days

331X

DUE TO (b) Repeated cerebral vascular accidents — for the past year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction — many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7, 1956, to Oct 30, 1957, that I last saw the deceased alive on Oct 30, 1957, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Erika P. Kraemer, M.D. — ADDRESS (Street, city or town, state): LAUREL SANITARIUM — DATE SIGNED: 10-30-1957

PHYSICIAN'S NAME (Type): ERIKA P. KRAEMER — LAUREL MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 1, 1957
22c. NAME OF CEMETERY OR CREMATORY: Oakwoods Cemetery
22d. LOCATION (City, town, or county) (State): Chicago Illinois

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Davidson — ADDRESS: Laurel, Md

24a. REC'D BY REGISTRAR DATE: NOV 5 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11033

11019 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The burial permit may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Prince Georges — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Laurel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md — COUNTY: Prince George

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel

STREET ADDRESS (If rural give location): 435 Main St

3. NAME OF DECEASED (Type or Print): (First) Infant Girl (Middle) (Last) Hurley

4. DATE OF DEATH (Month) (Day) (Year): 10-25-57, 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	S	10-24-57	yrs.		1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Laurel, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert C. Hurley

14. MOTHER'S MAIDEN NAME: Ruth Marsum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.: [redacted]

17. INFORMANT & ADDRESS: Robert C. Hurley, Laurel Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0 IMMEDIATE CAUSE (A): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSE(S) DUE TO (B): Newborn

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.):

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.:

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-24, 1957, to 10-25, 19 57, that I last saw the deceased alive on 10/24, 19 57, and that death occurred at 3 A.M, from the causes and on the date stated above.

SIGNATURE: Harold L Weaver M.D. — ADDRESS (Street, city, town, state): — DATE SIGNED: 10/26/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 10/26/57 — NAME OF CEMETERY OR CREMATORY: Ivy Hill Cemetery — LOCATION (City, town, or county) (State): Laurel, Md

24. REC'D BY REGISTRAR DATE: OCT 30 '57 — REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: [illegible] Laurel Md

2083294 XV5

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11068

CERTIFICATE OF DEATH

11035

Reg. Dist. No. 24-1

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Forestville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 3425 80th Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 N. Forestville
d. STREET ADDRESS: 3425 80th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur; Middle: ; Last: Jacobs

4. DATE OF DEATH: Month: Oct. Day: 15 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 14 1880

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Jacobs

14. MOTHER'S MAIDEN NAME: "Oak"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MR. Joe JACOBS Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few hours

420.0

DUE TO (b): Hypertensive Arterio Sclerotic Heart Disease — 10-12 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Severe Emphysema + Bronchial Asthma — 8-10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1956 to Oct 15, 1957, that I last saw the deceased alive on 10/14/57, 19, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sidney W Lowry M.D. — ADDRESS (Street, city or town, state): 7200-Marlboro Pike S.E Wash 28 — DATE SIGNED

PHYSICIAN'S NAME (Type): SIDNEY W LOWRY M.D. District Height, Md. 10/15/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-17-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layton & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 10/16/57

24b. REGISTRAR'S SIGNATURE: [illegible] Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG222 11-8-57 et

11020

CERTIFICATE OF DEATH

Reg. Dist. No. 11036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: None

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg x1
d. STREET ADDRESS: 4610 Annapolis Rd.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: M. — Last: Jefferson

4. DATE OF DEATH: Month: Oct — Day: 31 — Year: 1957

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 8-1886

9. AGE (In years last birthday): 71/70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Bordette Culley

14. MOTHER'S MAIDEN NAME: CORA HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert R. Jefferson — Address: 4610 Annapolis Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Block — INTERVAL BETWEEN ONSET AND DEATH: One hour
174X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): Cardiac Arrest
DUE TO (c): Coronary Thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY, Hour: o. m. / p. m. — Month: — Day: 12-15 — Year: 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 27, 1955 to Oct 31, 1957, that I last saw the deceased alive on Oct 31, 1957, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 1107-0 St NW Wash 5 D.C.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Dr J FRANCIS DYETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 4 '57
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial
22d. LOCATION (City, town, or county): Suitland (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry S. Washington & Son
ADDRESS: 467 N St. NW

24a. REC'D BY REGISTRAR DATE: NOV 4 '57
24b. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

; 11021

CERTIFICATE OF DEATH

11037
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PrinceGeorge General Hospita

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Fairmont Heights
d. STREET ADDRESS: 6025 Sheriff Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jane; Middle: ; Last: Johnson

4. DATE OF DEATH: Month: October; Day: 20; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 Aug. 1957

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 2; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Curtis Johnson

14. MOTHER'S MAIDEN NAME: Viola Rataliff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Viola Johnson 6025 Sheriff Rd, N.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Diarrhea — 4 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20, 1957, to 10/20, 1957, that I last saw the deceased alive on 10/20 1957, and that death occurred at 6.45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W Tukin M.D. ADDRESS (Street, city or town, state): 5301 Hamilton St. DATE SIGNED: 10/20/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-23-57
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Myrtle R. Rollins ADDRESS: 4334 Hunt Pl., N.E.

24a. REC'D BY REGISTRAR DATE: OCT 24 57

24b. REGISTRAR'S SIGNATURE:

227 7344 XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11038

11069 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4008-38th St. Apt. A1.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood 34
d. STREET ADDRESS: 4008 38th St. Apt. A1.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Effie Middle Alice Last Jones

4. DATE OF DEATH: Month 10 Day 17th Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/1/85
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Polo, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob Doy
14. MOTHER'S MAIDEN NAME: Libby Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.I.
16. SOCIAL SECURITY NO.: 579-18-7783
17. INFORMANT: Kinsey Jones — Address: Point Road Westport, Conn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	1 hour.
DUE TO (b)	Arteriosclerosis	—
DUE TO (c)		

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1, 1954 to Oct. 17, 1957, that I last saw the deceased alive on Oct. 17, 1957, and that death occurred at 3:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl W. Graff M.D. — ADDRESS (Street, city or town, state): 2716 Kirkwood Place — DATE SIGNED

PHYSICIAN'S NAME (Type): EARL W. GRAEFF, MD — W. Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/24/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Talley's Funeral Home — ADDRESS: Mt. Rainier Md.

24a. REC'D BY REGISTRAR DATE: OCT 23 '57
24b. REGISTRAR'S SIGNATURE: A. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11039

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bureau of the Census

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1423 West Virginia Ave N. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn — Middle: Aline — Last: Jones

4. DATE OF DEATH: Month: October — Day: 31 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1927

9. AGE (In years last birthday): 30 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Jones

14. MOTHER'S MAIDEN NAME: Melissa Whitfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. M. Jones — Address: 1423 West Va. Ave., N.E. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial Hemorrhage
DUE TO (b): Spontaneous rupture of cerebral artery
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour: o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 31, 1957

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL—CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11-5-57

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Mem

22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Frazier's Funeral Chapel Inc — ADDRESS: 389 R. I. Ave NE

24a. REC'D BY REGISTRAR DATE: NOV 4 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11071 11040

Reg. Dist. No. 243

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hall
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Central Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Hall
d. STREET ADDRESS: Central Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Warren — Last: Jones

4. DATE OF DEATH: Month: October — Day: 16 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1, 1957

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 4 — Days: 15 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Earl B. Jones

14. MOTHER'S MAIDEN NAME: Frances Ruth Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Frances Jones , Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Toxemia

DUE TO (c): Bronchopneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: October 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): —

22b. DATE THEREOF: Oct. 18 1957

22c. NAME OF CEMETERY OR CREMATORY: Mt Nebo

22d. LOCATION (City, town, or county): Mitchellville (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: A. A. Dorman — ADDRESS: Annapolis

24a. REC'D BY REGISTRAR DATE: OCT 22 1957

24b. REGISTRAR'S SIGNATURE: Agnes Yingling

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11022

CERTIFICATE OF DEATH

Reg. Dist. No. 11041

1. PLACE OF DEATH
a. COUNTY Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL
c. LENGTH OF STAY IN 1b adm. 4-22-54
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47 x-3
d. STREET ADDRESS 627 PENN. AVE S.E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First OTILIA Middle M. Last KENNELLY

4. DATE OF DEATH Month October Day 2 Year 1957

5. SEX Female
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 8-25-1869
9. AGE (In years last birthday) 88 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNING STORE 22
10b. KIND OF BUSINESS OR INDUSTRY Store
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME JOHN JSEMANN
14. MOTHER'S MAIDEN NAME OTILIA WALTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. 578-46-6515
17. INFORMANT Hospital Records — Address LAUREL SANITARIUM

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 days
334X
DUE TO (b) Chronic Brain syndrome associated with
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (c) Cerebral arteriosclerosis with psychotic reaction — many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7 — 1956, to Oct. 2 — 1957, that I last saw the deceased alive on October 2, 1957, and that death occurred at 12:15 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Erika P. Kraemer M.D. ADDRESS (Street, city or town, state) Laurel Sanitarium DATE SIGNED Oct. 2-1957
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER Laurel Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 5, 1957
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Washington, D.C. (State)

23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan ADDRESS James T. Ryan, Inc. 317 Pa. Ave., SE DC3
24a. REC'D BY REGISTRAR DATE OCT 4 57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11023 **CERTIFICATE OF DEATH** 11042

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Prince Georges Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): x2 Berwyn Heights
d. STREET ADDRESS: 6201 Semiole St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia — Middle: M — Last: Kidd

4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1890

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James Ozmar

14. MOTHER'S MAIDEN NAME: Kate Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Mrs Grace Humphreys — Address: Berwyn Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 7
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary arteriosclerosis — 6 months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to Oct. 12, 19 57, that I last saw the deceased alive on Oct. 12, 1957, and that death occurred at 11/30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leon R Levitsky M.D. — ADDRESS (Street, city or town, state): 3408 Rhode Island Ave Kenilworth — DATE SIGNED: 10/13/57

PHYSICIAN'S NAME (Type): Leon R. Levitsky

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation — 22b. DATE THEREOF: 10/13/57 — 22c. NAME OF CEMETERY OR CREMATORY: Petersburg — 22d. LOCATION (City, town, or county) (State): Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Maryland.

24a. REC'D BY REGISTRAR — DATE: OCT 15 '57 — 24b. REGISTRAR'S SIGNATURE: Geo. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11024

11043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL
c. LENGTH OF STAY IN 1b Born April 26 52
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION LAUREL SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47x-3
d. STREET ADDRESS 2675 Rhode Island Ave NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ABBIE Middle I. Last KINDER

4. DATE OF DEATH Month October Day 8 Year 1957

5. SEX female
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct. 6 1879
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME CHARLES CASSINS CLAY
14. MOTHER'S MAIDEN NAME JOSEPHINE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address HOSPITAL RECORDS, LAUREL SANITARIUM

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 8 days
420.1
DUE TO (b) arterio sclerotic Cardio-Vascular disease — many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): chronic Brain syndrome associated with cerebral arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June-7, 1956 to Oct-8, 1957, that I last saw the deceased alive on Oct-8-, 1957, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Erika P. Kraemer M.D. ADDRESS (Street, city or town, state) Laurel Sanitarium DATE SIGNED 10-8-57

PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER Laurel Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-11-57
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln
22d. LOCATION (City, town, or county) Bladensburg (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Neal Funeral Home 4817 Blaine Ave Washington
24a. REC'D BY REGISTRAR DATE OCT 14 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G222 10/31/57 fcv

11025

CERTIFICATE OF DEATH

11044

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY: PRINCE GEORGE MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: SAME b. COUNTY: P.G.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly BRENTWOOD — c. LENGTH OF STAY IN 1b: 4 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGE HOSP. – DOA	d. STREET ADDRESS: 4004-38 St. Brentwood Md. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: LEON; Middle: ; Last: KLAPPHOLZ
4. DATE OF DEATH	Month: Oct. Day: 23 Year: 1957
5. SEX	M
6. COLOR OR RACE	W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
8. DATE OF BIRTH	JAN 9, 1910
9. AGE (In years last birthday)	47 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	LAUNDRY WORKER
10b. KIND OF BUSINESS OR INDUSTRY	LAUNDRY
11. BIRTHPLACE (State or foreign country)	N. JERSEY
12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	HARRY
14. MOTHER'S MAIDEN NAME	ANN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	NO
16. SOCIAL SECURITY NO.	
17. INFORMANT	WIFE — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	PROB. CEREBRAL EMBOLUS	MINUTES
416 x — DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	RHEUMATIC HT. DISEASE	NOT KNOWN 6-10 YRS
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952 to 10-23 1957, that I last saw the deceased alive on 10-9 1957, and that death occurred at 8 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack J. Rheingold M.D. — ADDRESS (Street, city or town, state): 1302 18th St., N.W. Wash DC — DATE SIGNED: 10/23/57

PHYSICIAN'S NAME (Type): JACK J. RHEINGOLD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	OCT. 25, 1957	HEBREW CEMETERY	NEWARK N. J.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
B Danzansky & Son	3501-14 St N.W.	DATE Oct. 25, 1957	Mrs. Jas. Severe, Deputy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Have spoken with and cleared with Dr. Maloney, coroner

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG222 11-8-57 et

11026

11045

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 1 month 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Riverdale
d. STREET ADDRESS: 4706 Sheridan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mrs. Middle: Lydia Eleanora Last: Klaus

4. DATE OF DEATH: Month: October Day: 24 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-14-1883

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Otto August Hoffman

14. MOTHER'S MAIDEN NAME: Eleanora Schlicht

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): General debility — INTERVAL BETWEEN ONSET AND DEATH:

151X

DUE TO (b): Metastasis to Liver & Peritoneal cavity — 4 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Carcinoma of Stomach — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-8, 1957 to 10-24, 1957 that I last saw the deceased alive on 10-23, 1957, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R F Wilkinson M.D. — ADDRESS (Street, city or town, state): 4404 Queens Barry Rd — DATE SIGNED

PHYSICIAN'S NAME (Type): RF WILKINSON MD — Riverdale Md — 10/24/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/26/57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore

22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: Philip Henry Sons — ADDRESS: 2024 Orleans St

24a. REC'D BY REGISTRAR DATE: NOV 5 1957

24b. REGISTRAR'S SIGNATURE: James Devereux

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11027

CERTIFICATE OF DEATH

11046

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 ROGERS HEIGHTS
d. STREET ADDRESS: 5308 HAMILTON ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WADE — Middle — Last Koontz

4. DATE OF DEATH: Month OCT. — Day 20 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 6, 1902

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Navy yard

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob F. Koontz

14. MOTHER'S MAIDEN NAME: Anna Kisling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorothy Koontz — Address: 5308 Hamilton St. Rogers Heights Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension Arteriosclerotic Heart Disease 10 years.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1953, to 10-20-, 1957, that I last saw the deceased alive on 10-19-, 1957, and that death occurred at 11 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert Roth M.D. — ADDRESS (Street, city or town, state): Riverdale, Md. — DATE SIGNED: 10-21-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: OCT. 23, 1957

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or county) (State): Colmar Manor Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee — ADDRESS: Wash. D. C.

24a. REC'D BY REGISTRAR DATE: OCT 22 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11028 — 11047 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D. C. 47X-3
d. STREET ADDRESS: 3500 13th St N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gladys — Middle: Elizabeth — Last: Lancaster

4. DATE OF DEATH: Month: October — Day: 26, — Year: 19 57.

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 10, 1914

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government

11. BIRTHPLACE (State or foreign country): Piscataway, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jarriett T. Lancaster

14. MOTHER'S MAIDEN NAME: Irene J. Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mabel L. Johnson Brandywine, Md Route 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Crushed skull

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an auto that was in a collision

20c. TIME OF INJURY: Hour 2 p. m. — Month, Day, Year: 10-26 19 57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road

20f. (City or town) Accokeek (County) (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Oct 26, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10.31.57

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cat. Ch. Cemetery

22d. LOCATION (City, town, or county) (State): Piscataway, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert G. McGuire 1820 9th St, N.W. Wash., D.C.

24a. REC'D BY REGISTRAR — DATE: OCT 30 '57

24b. REGISTRAR'S SIGNATURE: Wm. Veirs

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11029 **CERTIFICATE OF DEATH** 11048

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 7208 Wells Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Marshall — Last: LaRue

4. DATE OF DEATH: Month: Oct. — Day: 28 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 Nov 1881

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Weeping Water, Nebr.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John T. Marshall

14. MOTHER'S MAIDEN NAME: Medella Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: George R. LaRue, Address: 7203 Wells Parkway Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
170×
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinomatosis
DUE TO
(c): Carcinoma of breast

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Oct. 28th, 1957, that I last saw the deceased alive on Oct. 28th, 1957, and that death occurred at 1.25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leon L Gallin M.D.
ADDRESS (Street, city or town, state): 7206 Colesville Road, Hyattsville, Md.
DATE SIGNED: 10/28/1957
PHYSICIAN'S NAME (Type): Dr. Leon L Gallin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 1/1957
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cem.
22d. LOCATION (City, town, or county) (State): Riggs Rd. Extd. Hyattsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 5301 Cleveland Ave. Riverdale Md
24a. REC'D BY REGISTRAR DATE: NOV 1 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11030 — Reg. Dist. No. 11049

FOR STATE HEALTH DEPT. — 1

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 4905 Erie Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Zeral — Middle: Osborne — Last: Law

4. DATE OF DEATH: Month: Oct. — Day: 5, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 2, 1895

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: D.C. Fireman

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Pinkney Law

14. MOTHER'S MAIDEN NAME: Sarah Francis McDowell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: John L. Law; 5102 Mineola Rd. College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cardiovascular disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Oct. 5, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/8/57
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEMETERY
22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: MARTIN W. HYSONG COMPANY
ADDRESS: 1300 N. STREET N.W. WASHINGTON, 5, D.C.

24a. REC'D BY REGISTRAR (Date): OCT 8 1957
24b. REGISTRAR'S SIGNATURE: James Stevens

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11031 11050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: 8 hrs 25 Min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGE'S GENERAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEAT PLEASANT,
d. STREET ADDRESS: 7022 Central Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle Mary Last LAURENZI

4. DATE OF DEATH: Month Oct Day 19 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: [redacted] Jan 10, 1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours 8 Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None H-Wife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Harry W. Geety
14. MOTHER'S MAIDEN NAME: EMMA (UNKNOWN)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 579-14-3826
17. INFORMANT: Harvey C. Laurenzi (Son) Address: 7022 Central Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

331 X

DUE TO (b): Cerebral arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 13, 1957, to Oct 19, 1957, that I last saw the deceased alive on Oct. 19, 1957, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter Duus M.D.
ADDRESS (Street, city or town, state): 6124 Central Ave. Cap. Hgts Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): DR. PETER DUUS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/24/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l.
22d. LOCATION (City, town, or county) (State): Ft. Myer Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 517-11th St SE Washington DC
24a. REC'D BY REGISTRAR DATE: OCT 22 57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11032

CERTIFICATE OF DEATH

11051

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Prince George's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Greenbelt, Md
d. STREET ADDRESS: 14 L Laurel Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stanley — Middle: — Last: Lawrence
4. DATE OF DEATH: Month: October — Day: 14, — Year: 19 57
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/23/57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months 21 Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Lawrence
14. MOTHER'S MAIDEN NAME: Margaret Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hospital records — Address: Cheverly, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 d
570.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Intestinal Obstruction — 2 d.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Strangulated Rt. Inguinal Hernia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 23, 19 57, to Oct 14, 19 57, that I last saw the deceased alive on Oct 13, 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William Eisner M.D. — ADDRESS (Street, city or town, state): 30B Ridge Rd Greenbelt Md — DATE SIGNED: 10/17/57
PHYSICIAN'S NAME (Type): William Eisner — Greenbelt, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/15/57
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 17 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2077283 X V5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11072

CERTIFICATE OF DEATH

Reg. Dist. No. 11052

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HILLCREST Hgths
c. LENGTH OF STAY IN 1b: 10 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5814 23rd Pl.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HILLCREST Hgths x2
d. STREET ADDRESS: 5814 23 Rd. Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHARLES Middle M.M.N. Last LAZZARI

4. DATE OF DEATH: Month OCTOBER Day 4 Year 1957

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: FEB 6 1890

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED Cook.

10b. KIND OF BUSINESS OR INDUSTRY: Hotel.

11. BIRTHPLACE (State or foreign country): Switzerland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LAURENCE LAZZARI

14. MOTHER'S MAIDEN NAME: MARIEA F. FERRO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: TINO LAZZARI Address: 5814 23rd PL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malnutrition — INTERVAL BETWEEN ONSET AND DEATH:
156.1
DUE TO
(b) Carcinoma of the liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 20, 1957, to October 4, 1957, that I last saw the deceased alive on October 3, 1957, and that death occurred at 11 a.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D. Etienne Szollosi M.D. ADDRESS (Street, city or town, state): 2 Parkway D. Forest Hgts DATE SIGNED: 10/4/57

PHYSICIAN'S NAME (Type): Dr. Etienne Szollosi

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-7-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 517-11th St. S.E.

24a. REC'D BY REGISTRAR DATE: OCT 7 1957

24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the re... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11033

11053

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md.
c. LENGTH OF STAY IN 1b: 3 days 23 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
d. STREET ADDRESS: 6402 L Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Lee

4. DATE OF DEATH: Month: 10 — Day: 23 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-19-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 3
IF UNDER 24 HRS.: Hours: 23 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Lee

14. MOTHER'S MAIDEN NAME: Dorothy Gaylord

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 762.5
(b): Prematurity — Immediate
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/19/, 1957, to 10/23/, 1957, that I last saw the deceased alive on 10/23/, 1957, and that death occurred at 10:45 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins, M.D.
ADDRESS (Street, city or town, state): 5301 Hamilton St. Hyattsville Md
DATE SIGNED: 11/23/57
PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-26-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Smithland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 517-11th St. S.E.

24a. REC'D BY REGISTRAR DATE: OCT 29 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

2077182 X VI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11034

CERTIFICATE OF DEATH

11054
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GENERAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 TAKOMA PARK
d. STREET ADDRESS: 6604 ALLEGHENY AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY GIRL — Middle: — Last: LEONARD

4. DATE OF DEATH: Month: OCTOBER — Day: 1 — Year: 19 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-30-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days 1 — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Henry Leonard

14. MOTHER'S MAIDEN NAME: Zilla Ann Bish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:
776 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/30, 19 57, to 10/1, 19 57, that I last saw the deceased alive on 10/1, 19 57, and that death occurred at 11:30AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William Brown M.D. — ADDRESS (Street, city or town, state): 612 Central Ave — DATE SIGNED: 10/4/57

PHYSICIAN'S NAME (Type): WM BRAININ — Capitol Heights Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 22b. DATE THEREOF: 10/15/57 — 22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital — 22d. LOCATION (City, town, or county) (State): Cheverly, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn Jr. — ADDRESS: Administration.

24a. REC'D BY REGISTRAR DATE: OCT 18 57 — 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

207721XV3

1.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10985 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11055 Reg. Dist. No. 214

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the local Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 807 Davis Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park
d. STREET ADDRESS: 807 Davis Avenue
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry — Middle: (nmi) — Last: Loveday

4. DATE OF DEATH: Month: October — Day: 2nd, — Year: 19 57

5. SEX: M le

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-12-90

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Government

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Loveday

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW#1

16. SOCIAL SECURITY NO.: 578-32-4496

17. INFORMANT — Address: Arnold Loveday; 2109 Brighton Rd. Avondale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary thrombosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiovascular renal disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-2-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 4, 1957

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Fort Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR (DATE): OCT 4 1957

24b. REGISTRAR'S SIGNATURE: Frances Pettyjohn A. R. Schuchardt

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1105

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant
c. LENGTH OF STAY IN 1b 14 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400-69th Place

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant
d. STREET ADDRESS 400-69th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Maggie Middle Linestand Last
4. DATE OF DEATH Month Oct Day 29 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Dec 20, 1883
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Julia Penfield Address Same as #7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
4427
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardiovascular renal disease
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James I. Boyd M.D.
EXAMINER'S NAME (Type) James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 10-29-57

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 10-31-57
22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or county) (State) Arlington, Va

23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee's Son ADDRESS 300-4th st NE-20C. WASH
24a. REC'D BY REGISTRAR DATE OCT 30 1957
24b. REGISTRAR'S SIGNATURE Carrie Campbell

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11035

CERTIFICATE OF DEATH

11057

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Edmonston
d. STREET ADDRESS: 4804 -52nd. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle Alma — Last Mahone

4. DATE OF DEATH: Month OCTOBER — Day 13 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.20th,1902

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Richmond, Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Thomas Gallagher

14. MOTHER'S MAIDEN NAME: Dora Frances Bowles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Walter E. Mahone, 4804--52nd Ave. Edmonston Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pentonitis & Sub diaphg. abcess — INTERVAL BETWEEN ONSET AND DEATH
572.0
DUE TO
(b): Regional Ileitis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____ to 10-13, 1957, that I last saw the deceased alive on 10-13-57, 19____, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dayton O Watkins M.D. — ADDRESS (Street, city or town, state): 5304 Annapolis Rd — DATE SIGNED: 10-15-57

PHYSICIAN'S NAME (Type): DAYTON O WATKINS — Bladensburg Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/16/1957

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Pr. Geo. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W W Chamber — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: OCT 16 '57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11058

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-11036

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights x2
d. STREET ADDRESS: 5908 21st Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Michele — Last: Marasciula

4. DATE OF DEATH: Month: October — Day: 13 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 19, 1925
9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): District of Columbia U. S. A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lawrence T. Vallario
14. MOTHER'S MAIDEN NAME: Antionette Pappa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Nicholas J. Marasciula, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Acute Carbon Monoxide Poisoning
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran motor of car while she was closed in garage
20c. TIME OF INJURY — Hour: 3:00 a. m. — Month, Day, Year: 10/13 57
20d. INJURY OCCURRED — While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Garage at home
20f. (City or town) Hillcrest Heights (County) P. G. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: October 13, 1957

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/16/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) Suitland, Maryland (State)

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan, Inc.
ADDRESS: 317 Penna. Ave., SE Washington 3, D.C.
24a. REC'D BY REGISTRAR — DATE: OCT 15 '57
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11059

11074

CERTIFICATE OF DEATH

Reg. Dist. No. 245

M

Field	Entry
1. PLACE OF DEATH a. COUNTY	PRINCE GEORGE MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	MD.
b. COUNTY	P.G.
1b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b	
2c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	xo CHILLUM
1d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
2d. STREET ADDRESS	5808-10th Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐	
3. NAME OF DECEASED (Type or print) First / Middle / Last	Alexander / / Mates
4. DATE OF DEATH Month / Day / Year	10 / 24 / 1957
5. SEX	M
6. COLOR OR RACE	W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	Widowed
8. DATE OF BIRTH	JAN-8-1894
9. AGE (In years last birthday)	63 yrs.
IF UNDER 1 YEAR Months / Days	
IF UNDER 24 HRS. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	MGR. RETAIL
10b. KIND OF BUSINESS OR INDUSTRY	LIQUOR STORE
11. BIRTHPLACE (State or foreign country)	RUSSIA
12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	HENRY-
14. MOTHER'S MAIDEN NAME	–
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	NO / –
16. SOCIAL SECURITY NO.	578-46-3399
17. INFORMANT / Address	BERNARD MATES, 1706-CROSBY RD. Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

	Cause	Interval between onset and death
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	Immed.
DUE TO (b)	Cerebral Arteriosclerosis	10 YRS
DUE TO (c)	Hypertensive C.V.D. - Severe.	10 YRS

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1950, to 10-24 1957, that I last saw the deceased alive on 10/22 1957, and that death occurred at 8:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William Kurstin M.D.

ADDRESS (Street, city or town, state): 915 19th St. NW

DATE SIGNED: 10/24/57

PHYSICIAN'S NAME (Type): William Kurstin MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	10/25/57	BNAI ISRAEL Cem	OXON HILL. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home ADDRESS: 4217-9th St NW

24a. REC'D BY REGISTRAR DATE: OCT 25 1957

24b. REGISTRAR'S SIGNATURE: James Seaney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Prince George County Coroner notified - will approve

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11060

Reg. Dist. No. 11037

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 41 Laurel
d. STREET ADDRESS: 502-9th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Edward — Last: Matthews
4. DATE OF DEATH: Month: Oct. — Day: 1, — Year: 1957

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. BIRTH: 4-23-26
9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Mckinley Matthews
14. MOTHER'S MAIDEN NAME: Gertrude Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: William Matthews; same as #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Gunshot wound of abdomen
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot by a police officer in the performance of his duties.
20c. TIME OF INJURY: Hour: 8.13 p. m. — Month, Day, Year: Oct. 2, 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Laurel. (County): Pr. Geo. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

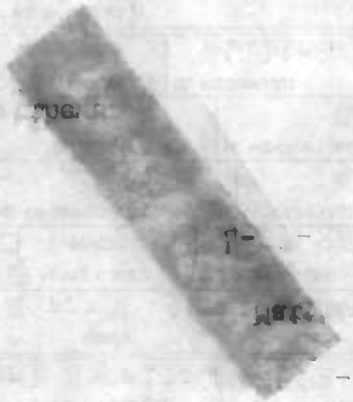
ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 1, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT 4/57
22c. NAME OF CEMETERY OR CREMATORY: NATIONAL MEMORIAL
22d. LOCATION (City, town, or county): BALTO (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ridgley Selby — ADDRESS: 401 Nash ave Laurel Md
24a. RECD BY REGISTRAR DATE: OCT 1 57
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55



FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11061

Items 3,6 Film C222 10-29-57 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1103 Lancaster Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park
d. STREET ADDRESS: 1103 Lancaster Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ~~Katherine~~ ~~Mooyer~~ (Catherine Middle: ~~Mooyer~~ Last: Mooyer
4. DATE OF DEATH: Month: October Day: 20, Year: 19 57
5. SEX: Female
6. COLOR OR RACE: ~~White~~ Color—
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-23-65
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Christopher Summerlot
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Margaret Wolf
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: George Spillman; same address.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular renal disease. — INTERVAL BETWEEN ONSET AND DEATH:
442 ×
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy no, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T Maloney M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: October 21, 1957
EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/24/57
22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
22d. LOCATION (City, town, or county) (State): Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John A. Moran 3000 E.Balto. St. Balto.
24a. REC'D BY REGISTRAR — DATE: OCT 23 57
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

~~11075~~ MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11062

Reg. Dist. No. 24-2

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Hill
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4500 Block St. Barnabas Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Hill
d. STREET ADDRESS: 5101 St. Barnabas Road S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Alvin — Last: Moreland

4. DATE OF DEATH: Month: Oct. — Day: 8 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 22, 1935

9. AGE (In years last Birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wilson Moreland

14. MOTHER'S MAIDEN NAME: Daisey Varnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Earl W. Moreland, 4340 St. Barnabas Road S.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH: D / C
823X
DUE TO (b): Compound fracture of th skull, crushed, abdomen and pelvis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple abraisions and contusion

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of an automobiel that ran off road and struck a pole

20c. TIME OF INJURY: Hour, a. m. or p. m.: 1:00 P.M. — Month, Day, Year: 10/ 8 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road

20f. (City or town): Silver Hill — (County): P.G. — (State): Md.

21. I certify that I taak charge of the remains described abave, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 10/8/57

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 10-57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Bladensburg, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Barber
ADDRESS: 1661 Good Hope Road SE, Washington 20, D.C.

24a. RECD BY REGISTRAR DATE: OCT 9 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11076

CERTIFICATE OF DEATH

Reg. Dist. No. 11063

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLENN DALE
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GLENN DALE HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DIST. OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X-3
d. STREET ADDRESS: 1609 VARNUM ST. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NICK — Middle (NONE) — Last NEAM
4. DATE OF DEATH: Month 10 — Day 16 — Year 19 57

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/17/189✓
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: DELICATESSEN
11. BIRTHPLACE (State or foreign country): SYRIA
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: JACOB NEAM
14. MOTHER'S MAIDEN NAME: CARRIE DAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: DECEASED — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
420.0
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): BRONCHOGENIC CARCINOMA RT. LUNG; RIGHT LOWER LOBECTOMY 10/8/57
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/1, 19 57, to 10/16, 19 57, that I last saw the deceased alive on 10/16, 19 57, and that death occurred at 11:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss M.D. — ADDRESS (Street, city or town, state): GLENN DALE HOSP. — DATE SIGNED: 10/16/57

PHYSICIAN'S NAME (Type): MOE WEISS MD. — GLENN DALE MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-19-57
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. A. Mun Co. — ADDRESS: 2901-14 Mt. P. Ave. Wash, D.C.
24a. REC'D BY REGISTRAR — DATE: OCT 18 57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11038

12262
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Mount Rainier
d. STREET ADDRESS: 5215 Rainier Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis; Middle: ; Last: Newyahr

4. DATE OF DEATH: Month: October; Day: 13; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-13-19

9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant

10b. KIND OF BUSINESS OR INDUSTRY: Gasoline service

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Newyahr

14. MOTHER'S MAIDEN NAME: Virginia Weaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Eleanor Govitch, Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH:
331x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John T. Maloney, M.D.
DATE SIGNED: October 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 17, 1957
22c. NAME OF CEMETERY OR CRXXXXXX: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR: OCT 18 '57
24b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11039

CERTIFICATE OF DEATH

Reg. Dist. No. 11064

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 19H 35M
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): E. Columbia Park,
d. STREET ADDRESS: 7719 Ridge Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: F — Last: Norton

4. DATE OF DEATH: Month: Oct. — Day: 27 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-21-70

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT: Mrs Zelkhia H. Raum — Address: 7719 Ridge Dr Landover. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pul. Edema & Aortic Stenosis
420.0
DUE TO (b): C my. heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Heart disease.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. ft. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/26, 1957, to 10/27, 1957, that I last saw the deceased alive on 10/27, 1957, and that death occurred at 2:25P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John Kehoe M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. John Kehoe

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 31, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers
ADDRESS: 519 11th St SE

24a. REC'D BY REGISTRAR DATE: 31 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages [illegible] and 2 should be filed with the [illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11040 — Reg. Dist. No. 11065

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 6206 Field Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ollie — Middle: B. — Last: Pace

4. DATE OF DEATH: Month: Oct. — Day: 9 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1894

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 3 / Min.: 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harvey Koon

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Murray Pace — Address: 6204 Field St Seat Pleasant Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure & Acute Pulmonary Edema
443X
DUE TO
(b): Hypertensive Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ? multiple myeloma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-1-, 1957, to 10-9-, 1957, that I last saw the deceased alive on 10-9-, 1957, and that death occurred at 1:18 p.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arnold A Lear M.D.
ADDRESS (Street, city or town, state): 905 Sheridan St Hyattsville, Md.
DATE SIGNED: 10-10-57
PHYSICIAN'S NAME (Type): ARNOLD A. LEAR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-14-57
22c. NAME OF CEMETERY OR CREMATORY: Washington National
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co.
ADDRESS: 517 11th St S.E.
24a. REC'D BY REGISTRAR DATE: OCT 14 57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the [illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11066

1. PLACE OF DEATH
a. COUNTY: Prince Georges 11041 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hattsville
d. STREET ADDRESS: 5602 16th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Anthony Last Phillips

4. DATE OF DEATH: Month October Day 17 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-21-18
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat cutter
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Phillips
14. MOTHER'S MAIDEN NAME: Dora McMurtry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dimple Phillips; Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
983 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Fractured skull
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Received during an altercation.
20c. TIME OF INJURY Hour 7.00 p. m. Month, Day, Year 10-16 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Food store
20f. (City or town) Mt. Rainier, (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 17, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 19, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 21 '57
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11077

11067

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLENN DALE
c. LENGTH OF STAY IN 1b: 1 YR 3 MO
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GLENN DALE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WASHINGTON — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CITY — 47x-3
d. STREET ADDRESS: 725 QUEBEC PL. N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

08

3. NAME OF DECEASED (Type or print): First OLIVIA — Middle P. — Last POWELL

4. DATE OF DEATH: Month OCT. — Day 5 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/21/10

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

I 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK TYPIST

10b. KIND OF BUSINESS OR INDUSTRY: FOREIGN CLAIM SETTL.

11. BIRTHPLACE (State or foreign country): MISSISSIPPI

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: DAN POSEY

14. MOTHER'S MAIDEN NAME: BESSIE DUCKSWORTH

0

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 577-52-3143

17. INFORMANT: DECEASED — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PULMONARY TUBERCULOSIS — INTERVAL BETWEEN ONSET AND DEATH: 7 YRS.

002X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/18/56, 19____, to 10/5, 19 57, that I last saw the deceased alive on 10/4, 1957, and that death occurred at 4:50 AM, from the causes and on the date stated above.

1

ACTUAL SIGNATURE: Moe Weiss M.D. M.D. — ADDRESS (Street, city or town, state): GLENN DALE HOSPITAL — DATE SIGNED: 10/5/57

PHYSICIAN'S NAME (Type): MOE WEISS M. D. — GLENN DALE, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 10/6/57

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Shuman & Shuman — ADDRESS: 1702 [illegible] ST

24a. REC'D BY REGISTRAR DATE: OCT 8 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11078 (11068) Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gregory Estates
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7010 Greg Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gregory Estates x2
d. STREET ADDRESS: 7010 Greg Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Howard — Last: Railey
4. DATE OF DEATH: Month: Oct — Day: 22 — Year: 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 17, 1915
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Operator
10b. KIND OF BUSINESS OR INDUSTRY: Stone
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George R Railey
14. MOTHER'S MAIDEN NAME: Pearl Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Florence M Stiene, Capital Hts, Md. Address: 5208 - Carlton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH
976X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gun shot wound of abdomen
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self in abdomen with shot gun
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 10-22-1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Gregory Estates P. G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME [Type]: JAMES T. Boyd
DATE SIGNED: Oct 22, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-25-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cem.
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 517-11th St. S. E.
24a. REC'D BY REGISTRAR: DATE: OCT 28 '57
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11042

CERTIFICATE OF DEATH

Reg. Dist. No. 11069

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 10 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Heights Estates
d. STREET ADDRESS 3900 Calventon Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Xerophen Last: Reid

4. DATE OF DEATH Month: Oct Day: 5 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 28, 1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Banker
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — daughter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs E.S. Earnhardt 3900 Calventon Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min
420.0
DUE TO (b) Arteriosclerotic Heart Disease — 10 yrs
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to Oct 5, 1957, that I last saw the deceased alive on Oct 5, 1957, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Norman Donat Comeau M.D.
ADDRESS (Street, city or town, state) 3503 Penny St
DATE SIGNED 10/5/57

PHYSICIAN'S NAME (Type) Norman Donat Comeau
Mt Rainier Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation
22b. DATE THEREOF: Oct 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: Hickory
22d. LOCATION (City, town, or county) (State): North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Maryland.
24a. REC'D BY REGISTRAR DATE: OCT 8 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10978

Items 8 & 9, Film G-222 11/19/57 c.

CERTIFICATE OF DEATH

11070

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 3929 NICHOLSON St (Home)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 HYATTSVILLE
d. STREET ADDRESS: 3929 NICHOLSON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CAROLYN Middle MILLER Last RICHARDS

4. DATE OF DEATH: Month OCT. Day 20 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 6, 1876

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Hope, Ky.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unk -

14. MOTHER'S MAIDEN NAME: Alice Humphry.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MRS HARRISON Hough (Name) Address (Street or R.F.D., No., City or Town, State): 4101 Oglethorpe St Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days
DUE TO (b): Cerebral Arteriosclerosis — 2+ years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1956, to Oct. 19, 1957, that I last saw the deceased alive on Oct. 19, 1957, and that death occurred at 4 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arnold A Lear M.D.
ADDRESS (Street, city or town, state): 905 Sheridan St. Hyattsville Maryland
DATE SIGNED: 10-20-57

PHYSICIAN'S NAME (Type): ARNOLD A LEAR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 22, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cone Hill Cemetery
22d. LOCATION (City, town, or county) (State): Louisville, Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wm Lees Sons Co. ADDRESS: 309 - 4 St NE Washington DC
24a. REC'D BY REGISTRAR DATE: OCT 22 1957
24b. REGISTRAR'S SIGNATURE: James Lowery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the ... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11071

~~11079~~

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill
c. LENGTH OF STAY IN 1b 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8921 - Old Fort Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chapel Hill
d. STREET ADDRESS 8921 Old Fort Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

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3. NAME OF DECEASED (Type or print) First: Walter Middle: R Last: Richards
4. DATE OF DEATH Month: Oct Day: 5 Year: 1957

I

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday) 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY General
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

0

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address 8920 Old Fort Rd Clarence A Chandler Chapel Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cardiovascular renal disease
DUE TO (c)

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE James J Boyd M.D.
EXAMINER'S NAME (Type) James J Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED Oct 5, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8 Oct 57
22c. NAME OF CEMETERY OR CREMATORY Woodlawn
22d. LOCATION (City, town, or county) (State) Wash., D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John T. Rhines Co. 901 3St., N.W. Wash., D.C.
24a. REC'D BY REGISTRAR DATE OCT 8 57
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [redacted] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar priar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11043

CERTIFICATE OF DEATH

Reg. Dist. No. 11072

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George Generil

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside X2
d. STREET ADDRESS: 4801 M. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: ; Last: Rupert

4. DATE OF DEATH: Month: Oct. Day: 26 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1882

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Goose Creek, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Stein

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Charles S Rupert — Address: Hillside Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senility — INTERVAL BETWEEN ONSET AND DEATH: yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic malnutrition — yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard A Lear M.D. — ADDRESS (Street, city or town, state): 905 Sheridan St — DATE SIGNED: 10-26-57

PHYSICIAN'S NAME (Type): Dr. H, Lear — Hyattsville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-30-1957

22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl

22d. LOCATION (City, town, or county) (State): Ft Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co — ADDRESS: 517-11th St. SE.

24a. REC'D BY REGISTRAR — DATE: OCT 30 57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 will be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the local Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11073 34

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7621 Walter's Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Forestville
d. STREET ADDRESS: 7621 Walters Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susan — Middle: Elizabeth — Last: Sackett
4. DATE OF DEATH: Month: October — Day: 23 — Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Personal papers — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
442 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cardiovascular renal disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James D. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 24, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): ✓
22b. DATE THEREOF: 10-24-57
22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
22d. LOCATION (City, town, or county) (State): Baltimore Md.
ADDRESS:

23. FUNERAL DIRECTOR'S SIGNATURE:

24a. REC'D BY REGISTRAR DATE: OCT 28 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10979

CERTIFICATE OF DEATH

Reg. Dist. No. 11075 245

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5701 - 42nd Ave,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8, o3xo.2
d. STREET ADDRESS Old Court Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Emma Middle M. Last Schildwachter
4. DATE OF DEATH Month Day Year
Birth 12 - 17 - 1923

5. SEX Female
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH (If death) 10/8/57
9. AGE (In years last birthday) 34 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS OR INDUSTRY Typist
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Carl T. Johnson Sr.
14. MOTHER'S MAIDEN NAME Ethel L. McIntosh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-16-0056
17. INFORMANT see above Address Pikesville, Md. Stephen L. Schildwachter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinomatosis	
175X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Primary Ca of Ovary	2 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify, that I attended the deceased from 6-15, 1957 to 10-8, 1957, that I last saw the deceased alive on 10-8-57, 19, and that death occurred at 4:12 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE John P. Clum M.D. ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 10-9-57
PHYSICIAN'S NAME (Type) John P. Clum

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/10/57
22c. NAME OF CEMETERY OR CREMATORY George Washington
22d. LOCATION (City, town, or county) (State) Riggs Rd. Hyattsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Bradley's Funeral Home Inc. ADDRESS Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE OCT 11 1957
24b. REGISTRAR'S SIGNATURE James E Seavey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

.11044

CERTIFICATE OF DEATH

11076
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 6109-39th Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Dorcas Middle C Last Scruggs
4. DATE OF DEATH Month Oct. Day 17 Year 1957

5. SEX Fem. 6. COLOR OR RACE W. 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 12-2-01 9. AGE (In years last birthday) 55 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Coy
14. MOTHER'S MAIDEN NAME Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT James M. Scruggs Address Hyattsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 11, 1957, to Oct 17, 1957, that I last saw the deceased alive on Oct 17, 1957, and that death occurred at 2:35 P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE T. L. Bergeman M.D.
PHYSICIAN'S NAME (Type) T. L. Bergeman

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/22/57
22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or county) (State) Arlington VA

23. FUNERAL DIRECTOR'S SIGNATURE F. Gracka & Sons ADDRESS Hyattsville Md
24a. REC'D BY REGISTRAR DATE OCT 21 '57
24b. REGISTRAR'S SIGNATURE Dorothy Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11045 | 11078 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, part 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince George
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md
c. LENGTH OF STAY IN 1b: 15 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 College Park
d. STREET ADDRESS: 8519 Potomac Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia Middle: Slater Last:
4. DATE OF DEATH: Month: Oct Day: 7 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-5-75
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: owh Home
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry Oden
14. MOTHER'S MAIDEN NAME: Josephine Harding

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Daughter, Mrs. Norman Fletcher Address: Hyattsville, Md 3910 Livingston Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio-Vascular Disease
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1957, to Oct, 1957, that I last saw the deceased alive on 10-6-57, 1957, and that death occurred at 6:55 M, from the causes and on the date stated above.
ACTUAL SIGNATURE: W L Etienne M.D.
ADDRESS (Street, city or town, state): 4713 Berwyn Rd College Park, Md
DATE SIGNED: 10-9-57
PHYSICIAN'S NAME (Type): W. L. ETIENNE

22a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
22b. DATE THEREOF: 10/12/57
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Masoleum
22d. LOCATION (City, town, or county) (State): Colmar Manor, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 11 '57
24b. REGISTRAR'S SIGNATURE

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11046

CERTIFICATE OF DEATH

11079

Reg. Dist. No. 245

M

1. PLACE OF DEATH
a. COUNTY Pr. Geo. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park
d. STREET ADDRESS 5100 Berwyn Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Amer Middle Curtis Last Smith
4. DATE OF DEATH Month 10 Day 5 Year 1957
5. SEX M
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 7-23-72
9. AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Blacksmith
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Curtis Smith
14. MOTHER'S MAIDEN NAME Rebecca Goddard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Address hosp. records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION, secondary to — INTERVAL BETWEEN ONSET AND DEATH
571.1
DUE TO old GASTRO-enteritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ___
DUE TO UREMIA
(c) ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1957, to Oct, 1957, that I last saw the deceased alive on Oct 4, 1957, and that death occurred at 1 20 P. M, from the causes and on the date stated above.
ACTUAL SIGNATURE W. L. Etienne M.D.
ADDRESS (Street, city or town, state) 4713 Berwyn Rd College Park, Md
DATE SIGNED 10-5-57
PHYSICIAN'S NAME (Type) W. L. ETIENNE

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/8/57
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.
22d. LOCATION (City, town, or county) (State) Bladensburg, Prince Geo's Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers
ADDRESS Co-Riverdale, Md
24a. REC'D BY REGISTRAR DATE OCT 9 1957
24b. REGISTRAR'S SIGNATURE James Lowery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11081 — 11084 — 3

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Prince William ~~Georges~~ — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MITCHELLVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 83x
d. STREET ADDRESS: 2232 N. Kentucky St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Smith

4. DATE OF DEATH: Month: October — Day: 8, — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 5, 1871

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Ebin R. Smith

14. MOTHER'S MAIDEN NAME: Mary S. Polley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Myrtle Earnshaw, Mitchellville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO (b): Hodgkins Disease — 3 1/2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491x 201x

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease, Myocardial Infarction — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/13, 1957, to 10/8, 1957, that I last saw the deceased alive on 10/5, 1957, and that death occurred at 9:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. James Kurtz, M.D. — ADDRESS (Street, city or town, state): RFD Bowie Md — DATE SIGNED: 10/8/57

PHYSICIAN'S NAME (Type): H. James Kurtz

22a. BURIAL, CREMATION, REMOVAL (Specify): burial — 22b. DATE THEREOF: Oct. 10, 1957 — 22c. NAME OF CEMETERY OR CREMATORY: Maury Cemetery — 22d. LOCATION (City, town, or county) (State): Richmond, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: C. P. Evans Sons — ADDRESS: 2847 Wilson Blvd. Arlington, Va.

24a. REC'D BY REGISTRAR DATE: 10-9-57 — 24b. REGISTRAR'S SIGNATURE: Beatrice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the [illegible] or prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11047

CERTIFICATE OF DEATH

11081
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 15
d. STREET ADDRESS: 6708 44th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: T. — Last: Cole — Snow

4. DATE OF DEATH: Month: October — Day: 1 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 7 75
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier- Woodward & Lothrop Store
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): W. Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: Arious Nye Cole
14. MOTHER'S MAIDEN NAME: Zidena Keller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph C. Cole-Arlington, Va. Address 44 S. Aberdeen St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
434.1
DUE TO (b): Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hemorrhoids, Osteo-arthritis Senile
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-22, 1957, to Oct, 1957, that I last saw the deceased alive on Oct 1, 1957, and that death occurred at 8:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M.L. Etienne M.D.
ADDRESS (Street, city or town, state): 4713 - Berwyn Rd College Park Md
DATE SIGNED: 10-2-57
PHYSICIAN'S NAME (Type): Dr. Walcott Etienne

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/5/57
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: The S.H. Hines Co. Washington, D. C.
24a. REC'D BY REGISTRAR DATE: OCT 8 '57
24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11048 11082

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 48 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5912 Jefferson Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MATHILDA Middle: (N.M.N.) Last: SOHL

4. DATE OF DEATH: Month: October Day: 21st, Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 15th, 1886
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Stapleton Staten Island, N.Y.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Mertens
14. MOTHER'S MAIDEN NAME: Louise (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 153-09-6139B
17. INFORMANT Address: Oliver A. Sohl, 5912 Jefferson St. Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac failure
450.0
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct.18th, 19 57 to Oct.21st, 19 57 that I last saw the deceased alive on Oct.21st, 19 57, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Deitz M.D.
ADDRESS (Street, city or town, state): Hyattsville, Md.
DATE SIGNED: 10/21/57
PHYSICIAN'S NAME (Type): A. Deitz

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/25/1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Pr.Geo.Co.Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.W.Chambers Company, Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: OCT 29 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11083
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meadows
c. LENGTH OF STAY IN 1b 25 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosaryville Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Meadows
d. STREET ADDRESS Rosaryville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Joseph Middle: Allen Last: Spencer
4. DATE OF DEATH Month: Oct Day: 14 Year: 1957
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday) 72 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY General
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Allen Spencer
14. MOTHER'S MAIDEN NAME Unknown
[redacted] Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Katie Spencer same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute congestive heart failure
4427
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular renal disease
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James I. Boyd M.D.
EXAMINER'S NAME (Type) James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED Oct 14, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/18/57
22c. NAME OF CEMETERY OR CREMATORY St. Luke Meth. Church Ceme.
22d. LOCATION (City, town, or county) (State) Meadows, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart ADDRESS 30 H Street, N.E.
24a. REC'D BY REGISTRAR DATE OCT 16 '57
24b. REGISTRAR'S SIGNATURE W. Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11049

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 4707 Edmonston Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Anthony — Last: Stavrakas

4. DATE OF DEATH: Month: October — Day: 7, — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-17-57

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 2 Days: 19 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Antonio Stavrakas

14. MOTHER'S MAIDEN NAME: Katherine Blair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father; same address — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
923.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Suffocation
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coryza

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suffocation in bed while suffering from coryza.

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 10-7- 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hyattsville (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John T. Maloney, M.D.
DATE SIGNED: October 7, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: OCT 11 57

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10980

CERTIFICATE OF DEATH

11085 245 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince George

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville

c. LENGTH OF STAY IN 1b: 5 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5809-44th. Ave.

d. STREET ADDRESS: 5809-44th. Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANGELO Middle (N.M.N.) Last STEFANELLI

4. DATE OF DEATH: Month October Day 10 Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 13, 1881

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Maker

10b. KIND OF BUSINESS OR INDUSTRY: Lackawana R.R.

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Salvatore V. Stefanelli

14. MOTHER'S MAIDEN NAME: Rosa Vallerine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 714-01-3921

17. INFORMANT: Cornelia Stefanelli Address: 5809-44th. Ave. Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Kidney & Metastasis. — INTERVAL BETWEEN ONSET AND DEATH: 10-15 Mo

DUE TO (b): Congestive Heart Failure — Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): 154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 19 55, to Oct 10, 19 57, that I last saw the deceased alive on Oct 10, 19 57, and that death occurred at 10:57 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert C. Wingfield M.D. ADDRESS (Street, city or town, state): Laurel Maryland-Returned 11-1957 DATE SIGNED

PHYSICIAN'S NAME (Type): ROBERT C. WINGFIELD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-14-57

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or county) (State): Suitland Pr Geo Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 5801-CLEVELAND AVE RIVERDALE MD.

24a. REC'D BY REGISTRAR DATE: OCT 15 1957

24b. REGISTRAR'S SIGNATURE: James Lenery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the r... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 FilmG222 11-4-57 et

CERTIFICATE OF DEATH

11083

Reg. Dist. No. 11086

1. PLACE OF DEATH
a. COUNTY: Prince George Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills Rural
c. LENGTH OF STAY IN 1b: 18 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 5575 Fisher Rd S.E

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Temple Hills
d. STREET ADDRESS: 5575 Fisher Rd S. E.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Willard Last: Takmon

4. DATE OF DEATH: Month: October Day: 27 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 24, 1897

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Painter

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: William Takmon

14. MOTHER'S MAIDEN NAME: Divine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I.

16. SOCIAL SECURITY NO.: 723-18-1878

17. INFORMANT Address: Annie Takmon, 5575 Fisher Rd S.E

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Infarct	3½ hours
DUE TO (b)	Coronary Infarct 420.1	4 yrs.
DUE TO (c)	Left Cerebral Thrombosis	2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral Femoral Thrombosis 7 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 1953 to October 1957 that I last saw the deceased alive on October 20 1957, and that death occurred at 1:20 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Anna Coyne Todd M.D. ADDRESS (Street, city or town, state): 7519 Broadview Rd S.E. DATE SIGNED: 10/27/57

PHYSICIAN'S NAME (Type): ANNA COYNE TODD, 7519 Broadview Rd S.E. D.C. 22 D.C. 22

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 29-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Simms Bros. ADDRESS: 1661 Good Hope Road S.E. Washington 20, D.C.

24a. REC'D BY REGISTRAR DATE: OCT 29 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

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2

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11087
Reg. Dist. No.

11050

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b Decedent Resident

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital
d. STREET ADDRESS 4803 R Street SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Carl Middle Franklin Last Teter
4. DATE OF DEATH Month Oct Day 5 Year 1957

5. SEX male
6. COLOR OR RACE white
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 21, 1893
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Franklin Teter
14. MOTHER'S MAIDEN NAME Marietta Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ethel G. Teter, same as #2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular renal disease
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) James I. Boyd
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED Oct 5, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 10-5-1957
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Suitland Pr Geo Co Md

23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661 Good Hope Rd SE
24a. REC'D BY REGISTRAR DATE OCT 7 '57
24b. REGISTRAR'S SIGNATURE A. W. Leavitt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11084

CERTIFICATE OF DEATH

11088
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES, MARYLAND MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLENN DALE, MARYLAND
c. LENGTH OF STAY IN 1b: 22 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GLENN DALE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WASHINGTON, D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D. C. 47x-9
d. STREET ADDRESS: 2515 15TH ST., N.W. APT. # 311
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES; Middle M.; Last THOMPSON

4. DATE OF DEATH: Month OCTOBER; Day 19; Year 19 57

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 22, 1901

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSTRUCTOR

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): RICHMOND, VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIS H. THOMPSON

14. MOTHER'S MAIDEN NAME: LUCY SCOTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 709-12-4802

17. INFORMANT: DECEASED
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANAPLASTIC CARCINOMA WITH WIDESPREAD — INTERVAL BETWEEN ONSET AND DEATH: 5 MOS.
180x
DUE TO
Condilians, if any, which gove rise lo immediate couse (a), stating the underlying couse last.
DUE TO (b): METASTASIS, PRIMARY SITE KIDNEY, LEFT
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): LEFT NEPHRECTOMY 6/57

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/27, 19 57, to 10/19, 1957, that I last saw the deceased alive on 10/19, 1957, and that death occurred at 9:15 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): GLENN DALE HOSPITAL, GLENN DALE, MD.
DATE SIGNED: 10/19/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 10/19/57
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Mem. Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert E McClure
ADDRESS: 1820 9th St NW
(McClure) (Funeral Service Chgs.)

24a. REC'D BY REGISTRAR DATE: OCT 22 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11085 — 11089 — Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4697 - Homer Ave

2. USUAL RESIDENCE (Where deceased lived. If Institution-Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland x2
d. STREET ADDRESS: 4697 - Homer Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Wentworth — Last: Thornton
4. DATE OF DEATH: Month: Oct — Day: 16 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 20, 1881
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman
10b. KIND OF BUSINESS OR INDUSTRY: Special
11. BIRTHPLACE (State or foreign country): District of Columbia U. S. A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jack Thornton
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles F Thornton — Address: 3818-75th Ave Destrict Hgts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
442 X
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot I taak chorge of the remains described above, held an Autopsy ☐, Inspectian ☒, Inquiry ☒, and find thot deoth resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): JAMES H. Boyd — Oct 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-18-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 3004 N. 9
24a. REC'D BY REGISTRAR DATE: OCT 18 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11051

CERTIFICATE OF DEATH

11090

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 18 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 15
d. STREET ADDRESS: 4626 42nd Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: W. — Last: Tise

4. DATE OF DEATH: Month: Oct — Day: 25 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-28-74

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Post Master

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Tise

14. MOTHER'S MAIDEN NAME: Rachel Wallis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Hospital Records Cheverly, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoid myocardia — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
570.5
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Intestinal Obstruction — 2 wks
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald W. Mitchell M.D.
ADDRESS (Street, city or town, state): 1746 K St NW, Wash 6 D.C.
DATE SIGNED:

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/28/57
22c. NAME OF CEMETERY OR CREMATORY: Palmwood
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Brack Sons
ADDRESS: Hyattsville Md

24a. REC'D BY REGISTRAR
DATE: OCT 28 '57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11052

CERTIFICATE OF DEATH

Reg. Dist. No. 11091

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Prince George

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md

c. LENGTH OF STAY IN 1b: 49 Days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Lanham Md

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

d. STREET ADDRESS: 1 4th & D Streets

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Josephine — Middle Clara — Last Tomczak

4. DATE OF DEATH: Month Oct — Day 7 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 26th, 1892

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Scranton, Penna.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Stankiewicz

14. MOTHER'S MAIDEN NAME: Mary Niazolkiwcz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Stanley J. Tomczak, Lanham, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic CA of Pelvis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

199.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 19, 1957 to Oct 7, 1957, that I last saw the deceased alive on Oct 8 1957, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. C. Hageage M.D. — ADDRESS (Street, city or town, state): 3308 Perry St. Mt. Rainier — DATE SIGNED: 10/9/57

PHYSICIAN'S NAME (Type): C. C. Hageage M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/10/1957

22c. NAME OF CEMETERY OR CREMATORY: George Washington Cem.

22d. LOCATION (City, town, or county) (State): Riggs Rd. Extd. Hyattsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co. — ADDRESS: Riverdale, Md.

24a. RECD. BY REGISTRAR — DATE

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11092

11086

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4900-52nd Place

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston x 2
d. STREET ADDRESS 4900-52nd Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LLOYD Middle A. Last TRAFTON

4. DATE OF DEATH Month October Day 8 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3/28/1903
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Steward
10b. KIND OF BUSINESS OR INDUSTRY Capital Yacht Club
11. BIRTHPLACE (State or foreign country) Maine
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Alvin J. Trafton
14. MOTHER'S MAIDEN NAME Ida Pinkerton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-01-8637
17. INFORMANT Barbara A. Hidding Daughter Address above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CARCINOMATOSIS	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Metastatic Carcinoma of Rectum	About 6 Mo
DUE TO (c)		

154 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 5, 1957 to Oct 8, 1957 that I last saw the deceased alive on Oct 7, 1957, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William D. Rosson M.D. ADDRESS (Street, city or town, state) 5304 Annapolis Rd. Bladensburg, Md. DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/10/57
22c. NAME OF CEMETERY OR CREMATORY Washington National
22d. LOCATION (City, town, or county) (State) Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Malloy's Funeral Home Inc. ADDRESS Mt. Rainier Md.

24a. REC'D BY REGISTRAR DATE OCT 11 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10981

CERTIFICATE OF DEATH

11093 245 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY PRINCE GEO. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE.
c. LENGTH OF STAY IN 1b 16 days.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION HYATTSVILLE CONV. HOME.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY PRINCE GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 W. HYATTSVILLE
d. STREET ADDRESS 12516 AVALON PL.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First GILBERT Middle W. Last UPTON
4. DATE OF DEATH Month OCT. Day 27 Year 1957
5. SEX M
6. COLOR OR RACE Wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH MAY 16 1867
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10b. KIND OF BUSINESS OR INDUSTRY BLACKSMITH
11. BIRTHPLACE (State or foreign country) W - VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SYLVESTER UPTON
14. MOTHER'S MAIDEN NAME UNKNOWN.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Records - Home MRS. SYBIL Simms (Dtr) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 30 min.
331X
DUE TO
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Generalized Arteriosclerosis — 10-12 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) HYPERTENSIVE CARDIOVASCULAR DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 1956, to Oct. 27, 1957, that I last saw the deceased alive on Oct. 20, 1957, and that death occurred at 5:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James L Laubach M.D. ADDRESS (Street, city or town, state) 1806 FOX St, Hyattsville, Md. DATE SIGNED 10/27/57

PHYSICIAN'S NAME (Type) James L. Laubach, M.D. 1806 FOX St, Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF Oct 29 1957
22c. NAME OF CEMETERY OR ~~CREMATORY~~ WILD WOOD
22d. LOCATION (City, town, or county) (State) Beckley W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE W. W. ALTAVULL ADDRESS 3603 14th St NW
24a. REC'D BY REGISTRAR DATE OCT 28 1957
24b. REGISTRAR'S SIGNATURE James Devaney

WNSUDC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11087 11094 240

Reg. Dist. No: 100

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brandywine
c. LENGTH OF STAY IN 1b: 11 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Route #1 Box 14

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brandywine
d. STREET ADDRESS: Rt #1 Box 14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Joseph — Middle Wilmer — Last Watson

4. DATE OF DEATH: Month Oct — Day 16 — Year 1957

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1897

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jailor

10b. KIND OF BUSINESS OR INDUSTRY: Marlboro Jail

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jeremiah Watson

14. MOTHER'S MAIDEN NAME: Mally Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNK

17. INFORMANT: Mrs Joseph W Watson, — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
9767
DUE TO (b): Gun-shot wound of head
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): Shot self in right temporal area

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 10-16 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Brandywine PG Md

21. I certify that I taak charge of the remains described above, held an Autapsy ☐, Inspectian ☑ Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I Boyd M.D.
EXAMINER'S NAME (Type): JAMES I Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: Oct 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-19-57

22c. NAME OF CEMETERY OR CREMATORY: Immanuel Meth. Con.

22d. LOCATION (City, town, or county) (State): Horsehead, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunte Funeral Home — ADDRESS: Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: 10/22/57

24b. REGISTRAR'S SIGNATURE: Justice H Young

OCT 24 57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register priar to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11088

CERTIFICATE OF DEATH

11095

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (RURAL)
c. LENGTH OF STAY IN 1b: 34 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x.3
d. STREET ADDRESS: 3541 - 10'th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alton — Middle: Lee — Last: Williams

4. DATE OF DEATH: Month: Oct. — Day: 3 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/13/21

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Williams

14. MOTHER'S MAIDEN NAME: Peary Lee Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 578-14-8953

17. INFORMANT — Address: Decedent

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
002x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pulmonary tuberculosis — 16 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 30, 1957, to October 3, 1957, that I last saw the deceased alive an October 3, 1957, and that death occurred at 3:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss M.D.
ADDRESS (Street, city or town, state): Glenn Dale Hospital, Glenn Dale, Md.
DATE SIGNED: 10/3/57

PHYSICIAN'S NAME (Type): Moe Weiss

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)

22b. DATE THEREOF: 10-8-1957

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: John T. Rhines & Co. by Kermit Abbott
ADDRESS: 901-3rd St N.W.

24a. REC'D BY REGISTRAR — DATE: OCT 8 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

OCT 8 1957

BUREAU V. S